

**Towards the National Health Assembly II
Booklet 3**

Women's Health



**National Coordination Committee,
Jan Swasthya Abhiyan**

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NATIONAL COORDINATION COMMITTEE MEMBERS

- * All India People's Science Network (AIPSN)
- * All India Drug Action Network (AIDAN)
- * Asian Community Health Action Network (ACHAN)
- * All India Democratic Women's Association (AIDWA)
- * Association for India's Development (AID India)
- * Bharat Gyan Vigyan Samiti (BGVS)
- * Breastfeeding Promotion Network of India (BPNI)
- * Catholic Health Association of India (CHAI)
- * Centre for Community Health and Social Medicine , JNU
- * Centre for Health Enquiry into Health and Allied Themes (CEHAT)
- * Christian Medical Association of India (CMAI)
- * Society for Community Health Awareness, Research and Action (SOCHARA)
- * Forum for Creche and Child Care Services (FORCES)
- * Federation of Medical Representative Associations of India (FMRAI)
- * Joint Women's Programme (JWP)
- * Medico Friends Circle (MFC)
- * National Alliance of People's Movements (NAPM)
- * National Federation of Indian Women (NFIW)
- * National Association of Women's Organizations (NAWO)
- * Ramakrishna Mission (RK)
- * Voluntary Health Association of India (VHAI)

Participating organisations

Over 1000 organisations concerned with health care and health policy from both within and outside the above networks, have joined the Jan Swasthya Abhiyan campaign as participating organisations.

About the Jan Swasthya Abhiyan

In 1978 at Alma Ata, the governments of the world came together to sign the Alma Ata Declaration that promised "Health for All by 2000". However this promise was never taken very seriously and was subsequently marginalised in health policy discussions.

As the year 2000 approached it appeared that "Health for All by 2000" was quietly being forgotten by governments around the world. To remind people of this forgotten commitment the First People's Health Assembly was organised in Savar, Bangladesh in December 2000. The People's Health Assembly was a coming together of people's movements and other non-government civil society organisations all over the world to reiterate the pledge for Health for All and to make governments take this promise seriously. The assembly also aimed to build global solidarity, and to bring together people's movements and organisations working to advance the people's health in the context of policies of globalisation.

The national networks and organisations that had come together to organize the National Health Assembly, decided to continue and develop this movement in the form of the Jan Swasthya Abhiyan (People's Health Movement). Jan Swasthya Abhiyan forms the Indian regional circle of the global People's Health Movement..

Despite medical advances and increasing average life expectancy, there is disturbing evidence of rising disparities in health status among people worldwide. Enduring poverty with all its facets and in addition, resurgence of communicable diseases including the HIV/AIDS epidemic, and weakening of public health systems is leading to reversal of previous health gains. This development is associated with widening gaps in income and shrinking access to social services, as well as persistent racial and gender imbalances. Traditional systems of knowledge and health are under threat.

These trends are to a large extent the result of the inequitable structure of the world economy, which has been further skewed by structural adjustment policies, the persistent indebtedness of the South, unfair world trade arrangements and uncontrolled financial speculation - all part of the rapid movement towards inequitable globalisation. In many countries, these problems are compounded by lack of coordination between governments and international agencies, and stagnant or declining public health budgets. Within the health sector, failure to implement primary health care policies as originally conceived has significantly aggravated the global health crisis. These deficiencies include:

- A retreat from the goal of comprehensive national health and drug policies as part of overall social policy.
- A lack of insight into the inter-sectoral nature of health problems and the failure to make health a priority in all sectors of society.

- A failure to promote participation and genuine involvement of communities in their own health development.
- Reduced state responsibility at all levels as a consequence of widespread and usually inequitable policies of privatisation of health services.
- A narrow, top-down, technology-oriented view of health and increasingly viewing health care as a commodity rather than as a human right.
- It is with this perspective that the organisations constituting the Jan Swasthya Abhiyan have come together to launch a movement, emerging from the Peoples Health Assembly process. Some objectives that this coalition set for itself (which are set out in detail in the Peoples Health Charter) can be listed briefly as below:
- The Jan Swasthya Abhiyan aims to draw public attention to the adverse impact of the policies of iniquitous globalisation on the health of Indian people, especially on the health of the poor.
- The Jan Swasthya Abhiyan aims to focus public attention on the passing of the year 2000 without the fulfillment of the 'Health for All by 2000 A.D.' pledge. This historic commitment needs to be renewed and taken forward, with the slogan 'Health for All - Now!' and in the form of the campaign to establish the Right to Health and Health Care as basic human rights. Health and equitable development need to be reestablished as priorities in local, national, international policy-making, with Primary Health Care as a major strategy for achieving these priorities.
- In India, globalisation's thrust for privatisation and retreat of the state with poor regulatory mechanisms has exacerbated the trends to commercialise medical care. Irrational, unethical and exploitative medical practices are flourishing and growing. The Jan Swasthya Abhiyan expresses the need to confront such commercialisation, while establishing minimum standards and rational treatment guidelines for health care.
- In the Indian context, top down, bureaucratic, fragmented techno-centric approaches to health care have created considerable wastage of scarce resources and have failed to deliver significant health improvements. The Jan Swasthya Abhiyan seeks to emphasize the urgent need to promote decentralisation of health care and build up integrated, comprehensive and participatory approaches to health care that places "Peoples Health in Peoples Hands".

The Jan Swasthya Abhiyan seeks to network with all those interested in promoting peoples' health. It seeks to unleash a wide variety of people's initiatives that would help the poor and the marginalised to organise and access better health care, while contributing to building long-term and sustainable solutions to health problems

The Jan Swasthya Abhiyan is being coordinated by National Coordination Committee consisting of 21 major all India networks of peoples movements and NGOs. This is the third book in a six booklet series brought out by the NCC for the NHA II.

Contents

Introduction.....	9
Section I	
Some Determinants of Women's Health	12
Section II	
Critical Analysis of Healthcare Situation	37
Section III	
Consequences for women's health	49
Section IV	
Health Policies, Programmes pertaining to Women's Health .	64
Section V	
Medicines and Women's Health	77

Introduction

Health is not just about illness and treatment but is a state of well being free from physical, mental and social stress. Hence when there is abject poverty, even the best medical infrastructure will not be able ensure that people would be able to access it, or they would be healthy. This is because there are other social, cultural and economic and environmental factors that affect a person's health.

In a polluted environment, it is not possible for a person to remain healthy. When a family is evicted/displaced from its habitat to make way for a development project, (and obviously not rehabilitated), it affects their mental and physical health. When a person of a disadvantaged caste or tribe is

Not only that! Our continuous overwork with low wage, living conditions, poor access to health system and other resources as well as social exclusion determines our health and lead to inequalities in health

So our income level, poor housing conditions and unsafe workplace do affect our health.

constantly subjected to humiliation and violence by the upper castes, we cannot expect him or her to be healthy. Similarly, when a woman is constantly subjected to

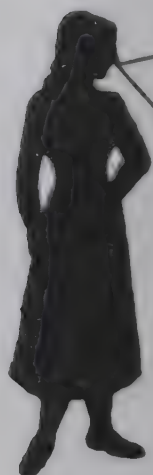


subjugation, humiliation and violence within own family, or she is gang raped and tortured in a communal riot, she cannot be healthy. Therefore, it is important to make linkages with all other issues that affect people's lives, with health¹.

Women's health is integrally linked to women's access to

¹Sama-Paper on Women's Access to Healthcare as a Fundamental Right

available resources, and with women's productive and reproductive



Sufferings and indignation of an Indian woman today begin from the time she is in the womb. The sex determination test and sex selective abortion are the example that how women have to struggle in order to survive!

roles in our society. On the one hand resources are increasingly slipping out of people's control, particularly women's, while on the other, she is severely subjugated in the family and society. This double burden carried by women

explains their chronic state of malnutrition, overwork and fatigue. Added to these are the stresses and strains of modern life, environmental degradation and increasing insecurity and violence.

Moreover, the process of globalisation, liberalisation and

Lets understand our living and working environment, our access and control over resources and the discrimination and violence we constantly struggle against!

economic reorganisation through privatisation has led to the weakening of the position of women in the public sector and their bargaining power. In the labour market there is increasing pressure on women's time and energy, even though their wages



are on the decline, and the virtual absence of support services adversely affects women's health. Due to the Structural Adjustment Programmes and economic reforms there has been a rise in unequal gender relations, reduced expenditure on public provision on health, education and social services, slowing down of growth

of industrial production, reduction in annual average growth rate (7.85 in 1980-81 to 5.95 in 1997-98)², shrinkage of food availability

²Sharma, Kumud (2002) 'Economic Policy and Women's Health' in Renu Khanna, Mira Shiva & Sarala Gopalan (ed) Towards Comprehensive Women's Health Programme and Policy: SALLA for Women & Health (WALL), cited in Sama- Dossier on Women's Right to Health, for UGC through NHRC

to poor families (Public Distribution Systems have not been able to address the needs of the poor families), declining real incomes of the poor etc. and all of these make poor women vulnerable to health problems.

There is urgent need to have a broader understanding of health as the interaction of socio-economic and political factors, based on the Primary Health Care Approach. This would help to address women's health needs more holistically; and provide preventive, promotional and curative care from a gender sensitive point of view.

Before delving into the limitations of the health system and the consequent demands to recognize women's right to health and healthcare as a fundamental right, it is important to understand the state of women's health and some of the underlying factors that determine it.

Section I

Some Determinants of Women's Health

Poverty, geographical location, social exclusion based on caste, gender, sexuality, disability interact closely with factors like work, housing, environment, education etc. to determine women's health. Although some of these factors affect the general population too, women experience them differently due to their lower status in society. It is important therefore to understand how women are particularly impacted and their health outcomes. There is critical need to look at women's health holistically as a sum total of their social environments and lived experiences towards understanding their health problems, as against adopting a narrow bio medical approach. This section

Women are always paid less and largely involved in informal and unpaid work



We have limited political participation.
No major changes in laws & policies to promote our right to land & property,



We have limited access to forests, rivers, traditional sources of food & medicine.
Privatisation of services and of subsidy reduction affecting access to education, food, water & healthcare



attempts to reflect women's lives in the context of their work, housing, access to food, water and other resources.

Poverty

Poverty underlies the poor health status of most of the Indian population, and women represent a disproportionate share of the

DO YOU KNOW?

- 71% of Dalit women are agricultural labourers., 90% cultivators
- 32-40% of the household sector and a large number of them are employed in unorganised labour in urban areas.
- Almost all Dalit women enter the labour market before the age of 20 years.
- Almost 31.6% of girls are child labourers (Guntur, AP).
- Dalit literacy rates- 23.76% out of which 19.46% exist in rural areas.
- Dalit girls dropout rates - 53.96%
- People from the poorest strata, despite having more health problems are six times less likely to get access to hospitalisation than people from the richer sections. This implies that women, especially from dalit, adivasi and other marginalised communities are less likely to afford and get access to hospitalisation when required.

poor. Poor health in turn contributes* to poverty among women. When women are sick, they cannot work in the home or in the paid labor force. In India, a study found that productivity in the female labor force would be about 20% higher if women's health problems were addressed.

Patriarchal (social norms) define men's and women's roles and access to resources. Women have traditionally been denied access to land and property, education, work opportunities and have been largely kept out of the decision making processes. Amongst women these norms particularly deny Dalit women and women from other

'Studies reveal that 90 percent of those who die of starvation and attendant diseases are Dalits. According to the National Commission for SC/ST , 2000, almost 75% of Dalit girls drop out of primary school in spite of reservations and academic aptitude, because of poverty, humiliation, isolation or bullying by teachers and classmates and punishment for scoring good grades.'



Towards the National Health Assembly II

marginalised communities access and hence they continue to live in abysmal poverty.

In the past decade women living in poverty have disproportionately increased in comparison with men. The unjust social, economic and political policies, as a result of globalisation, and privatisation have only made women poorer.

In this situation of increasing poverty, women who are primarily responsible for holding the family together, are forced to take up work at lower wages in extremely poor working conditions as compared to men. Women are also displaced from work due to rising unemployment levels and the arrival of technology requiring skilled labour.

Children, especially girls are increasingly dropping out from schools so that they can enter the largely unregulated underpaid informal labour force to help cope with rising prices of goods and services or to help with the household work as the provision of basic services and subsidies by the state are reduced or withdrawn.

Consumption of food is limited – both quantity and quality-impacting girls and women the most. This is particularly true for dalit, adivasi and women from other marginalised communities. Social exclusion based on caste and poverty supports each other. The extremely low social status of dalits, for example, results in poverty and poverty in turn intensifies their already poor social status.

Remember, discrimination on the basis of disability, sexuality and caste play a critical role in determining the health status of women.

Social Exclusion

Gender-based Discrimination

Women's relatively low status and the risks associated with reproduction exacerbate what is already an unfavourable overall health situation.

Gender based discrimination begins early and is evident in the falling sex ratio and the indiscriminate use of



technologies to 'get rid' of girls even before they are born. Girls are typically married as young adolescents and are taken from their natal homes to live in their husbands' households. There are subjugated not only by the men they have married but also by their in-laws. In most circumstances the money they earn, the dwellings in which they live, and even their reproductive 'choices' are not theirs to control. Women rarely have any autonomy in decision-making regarding their own bodies, sexualities, fertility. Women's mobility, particularly young women's is often controlled. In addition, the work they perform is devalued.

The consequence of women's unfavorable status in India is reflected in discrimination in the allocation of resources such as food, education, health care, access to information etc. This inequity in the distribution of resources, the subordinate social, political and economic status, and their reproductive role results in women being disproportionately vulnerable in the health outcomes. This inherently inequitable social system is perpetuated through a process of socialisation that rationalizes and internalizes the unequal status. Women are socialised in a way to devalue their health and therefore healthcare for them is given low priority. Women rarely have the power or opportunity to make decisions about their lives and health both at the micro and the macro -level and there is an absence of spaces and opportunities where they can express their needs and decide their priorities.

Caste-based Discrimination

In addition to discrimination due to gender and class, women

The health system also uses violence to maintain the traditional norms, assuming that any other expression is an aberration. Shock therapy and drugs are used to 'cure' us, but we are as normal as heterosexual.



also face discrimination based on caste. Dalit women first and foremost suffer tremendous exploitation, indignities and violence by the upper castes / classes and by the state.

Towards the National Health Assembly II

This in addition to gender based discrimination and due to poverty or economic status forms a triple burden for Dalit women. 'In India around 66 million women are Dalits and comprise 48 percent of the total Dalit population. Of the 16.3 percent of Dalit women population in India, 81.4 percent live in rural areas.'³

Caste based discrimination imposes social exclusion on Dalits and their physical separation from other castes not only in education but also in housing, religious institutions and social events. Dalits are prohibited from dining at public places, and are forced to do caste based work considered to be unclean, such as cleaning toilets, skinning and disposing of dead animals, digging graves, manual scavenging and carrying of night soil by women. Majority of the Dalit women in the rural areas work as bonded agricultural labourers with low / underpaid wages.

Dalit women have to struggle against discrimination by institutions of law enforcement and even healthcare. Their access to resources such as land, food, water, education, health services etc is minimal.

Discrimination based on Disability

When will my burden lessen!



Women with disabilities are among the most marginalized in Indian society. Women with disabilities are multiply disadvantaged because of their status as women, based on caste, as persons with disabilities, and because of poverty. A majority of women with disabilities live in poverty, which limits access to resources. This limited access in turn perpetuates poverty and causes disability. This cycle of poverty and disability deprives women of political, social, economic, opportunities, including access to education and healthcare. ***Women with disabilities are invisible and are left out of decision making processes due to rigid social norms that dictate***

what is normal and acceptable. Women with disabilities are not a

³ Rajni Tilak, Sana Das: Indian Dalit Women: Life After Liberalisation.
<http://www.worlddignityforum.org/indialalitwomen.aspx>

homogeneous group. Disabilities range from those resulting for example, from restricted mobility as a consequence of age, due to mental illnesses, mental retardation, the visually, hearing and speech impaired and those with so-called “medical disabilities”. All of these disabilities experience different kinds of barriers, which have to be overcome in different ways¹. Disability is thus a cause and consequence of poor health status.

Discrimination based on sexuality

Social and political norms define ‘normal’ sexuality. Normal sexuality is assumed

to be and mostly limited to sexual relationships that are heterosexual, monogamous, marital, procreative, same-caste, religion, class etc.

Construction of sexuality is political and some sexuality is constructed as immoral, obscene, and other sexualities

are accepted as the norm. Such construction assigns a certain power to the ‘normal’ and the good sexuality and denies power to the ‘abnormal’ and ‘bad’ sexuality.

Sexualities that do not fall within the ‘normal’ are oppressed, denied their right to health. Sex workers, sexual minorities and other women who don’t fall into the heteronormative, procreative, same caste, and class etc framework are marginalised and often face violence from communities. This impacts their health. Apart from this the

Of the 29.4 crore working class population in India only around 10% are in the organized sector and of rest 90% belonging to the unorganised sector, 89% are women. We are paid lesser wages than our male counterparts in the same sector and face constraints and oppression in all occupations.



¹Indumathi Rao, Member-Advisor, Committee on Women With Disabilities. National Commission for Women, Equity to Women with Disabilities in India. <http://www.disabilityworld.org/>

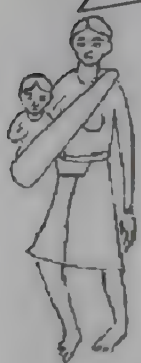
Towards the National Health Assembly II

health services neither at the policy nor at the implementation level (except in a very narrow context of HIV/AIDS), acknowledges diverse sexualities and hence does not provide healthcare to persons outside this norm.

As a result, policies and programmes are focused on married men and women, on reproduction within this marital framework. Expression of sexuality outside this framework, for example, is penalised and/ or ignored, and health information and services related to sexual health is denied to women with disabilities, adolescent girls, single women, older (post menopausal) women etc.

Work and Environment

Women are undermined as workers, defined as housewives and forced to a status of invisibility. They engage in different kinds of work, within and outside the domestic sphere, but it continues to be a long



"The National Commission for Labour says that 85% of Dalit women have the most formidable occupations. Some are agricultural labourers, scavengers, sweepers, and disposers of human waste. Others are small scale industry workers, construction workers, tailors, night-school teachers or as unorganised labour (domestic workers, sex workers, casual workers).

struggle to even get women's work recognized as work. Though its been widely recognized and acknowledged that the burden of domestic work, child

rearing and care of house-hold members, constitutes a major chunk of work undertaken by women, there is a limited understanding of what it actually involves. Cooking, cleaning, washing, feeding, tending to the sick, collection of water, fodder, fuel wood etc. consume a major part of women's time and energy.

Environmental pollution, deforestation, big dams, high ways, mining, industrial disasters like the Bhopal gas tragedy, privatisation of coastal sea resources, tourism, sanctuaries destroy and deplete resources and restrict women's access to them. This further adds to

CASE STUDY

Malar (17) comes from a Dalit family, her parents work as agricultural laborers. She has studied upto the 9th standard. She has been working with the A. Pharma for the past couple of couple of years. She hardly finds time to share the domestic work with her mother. Her day begins at about 5 in the morning. Since there is no toilet facility at her home, she and her mother have to answer their natures call in the cover of darkness. She leaves home for work around 7 a.m and takes a van to the factory. Most of the fellow travelers are women working in various units of the estate. The shift begins at 8.30 a.m and ends at 5p.m with a thirty minute lunch break. Most of the days she has to work over time and reaches home around 8.30 p.m. She feels very tired, both in the morning and in the evening and finds it too difficult to share the domestic works with her mother. She goes to bed immediately after supper. She feels that this is a luxury and will lose it when she gets married. She says this has happened with most of her fellow workers. Moreover she can continue to work in the unit till she gets married.

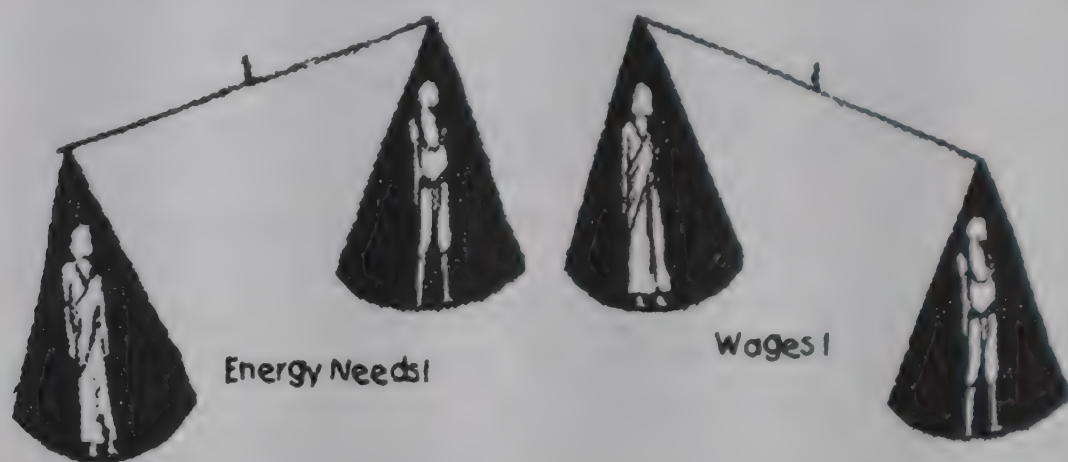
Invariably, when the order books of the company overflow, the workers are pressured to work overtime. The extended shift generally comes to a close around 7.30 p.m. The company vehicles drop the women workers at their villages. They reach home between 8.30p.m to 9.p.m. For married women this has resulted in a sharp friction in their patriarchal households, where their husbands have strongly protested against such overtime work. The husbands have gate crashed into the unit and wanted the practice of overtime to stopped. Since then, the unit employs only unmarried women on contract basis; women workers are retrenched as soon as they get married.

Malar is paid a monthly salary of Rs 750 and for the overtime she is compensated with 3 days leave in a month. She is supplied with protective gear like caps gloves facemask etc while she is at work. The unit has several processes like bottle washing, checking the bottles, batch taking, mixing, filling, packing and sealing. Women workers are employed in all the processes except batch taking and mixing. The production target is stiff. A team usually consists of 18 workers. They have to produce 450 boxes of medicine and each box contains 25 bottles. However on an average a team produces about 415 boxes a day.

The most unforgettable incident in her working life is an accident in the factory. One of her friends was working in the sealing section when the glass bottle exploded. The glass fragments pierced her face and she fainted. She was rushed to the hospital and admitted there for more than a week. She was rushed back to the hospital and was admitted there for more than a week. She got back to work after a fortnight, but the scar remains.

Towards the National Health Assembly II

women's burden and ill health, particularly affecting the marginalised communities Adivasis, Dalits, and women from other marginalised groups. The indirect impact of degradation-such as severe drought or deforestation-induced floods also hits the poor, Dalit, Adivasis women and women from other marginalised communities the hardest, as they are most likely to be evicted, to migrate, to be denied



livelihoods etc. Poverty in these cases is a direct outcome of environmental destruction, causing very serious health problems for women⁵.

Evictions and migration destroys the traditional health patterns and systems which have evolved out of generations of people living in a specific community and environment and does not provide adequate alternative resources for livelihood, eroding community relationships and support systems. In most instances eviction is enforced unfairly, without adequate and fair compensation, resulting in sheer poverty. Girls and women in such poverty stricken situations may face desertion, sexual trafficking, harassment etc, increasing the risk of being exposed to various health problems⁶.

Women with disabilities earn only 56% of the amount that men with disabilities earn. Disabled women earn the lowest wages compared to disabled men or non-disabled women. In order to be gainfully employed women put up with conditions of insecurity, low

⁵www.infochangeindia.org/Environment/

⁶Narmada Bachao Andolan, Health Rights in Situations of Conflict and Displacement. Paper presented at NHRC National Public Hearing, 2004

wages, long hours of work, unhealthy conditions and often sexual harassment. The situation of Dalit women is particularly vulnerable because of their extreme poverty and secondly the caste-based perception of looking at them as 'available'⁷.

The most strenuous work is usually done by women, for example,

in agriculture of
planting,
harvesting
weeding
etc, is
women's
work.

Similarly
collecting fuel and water
are also women's

responsibilities.

Barriers due to caste, class, gender, disability and sexuality further marginalise their position both at home and at the work place.

Women with disabilities have very few opportunities to work due to social attitudes towards them and the inaccessible physical environment, which hinders mobility.

Further the advent of technological innovations has also transformed the nature of work women do. If labour is displaced by new technologies, it is often women who are affected and they are rarely given trainings on the mechanised processes, so their absorption back into the workforce becomes problematic⁸. Dalit women are most affected by cuts in jobs, as these job losses are usually in the informal sector, in small firms, and among unskilled

⁷Rajni Tilak, Sana Das, Indian Dalit Women: Life after Liberalisation,
<http://www.worlddignityforum.org/indiandalitwomen.aspx>

⁸Shramshakti

and low skilled workers, which comprise of a large number of dalit women.

Globalisation has also led to the establishment of Export Processing Zones (EPZ) / Special Economic Zones (SEZ) to attract foreign investors. These employ a large number of women workers, who are largely exploited and overworked, as the labour laws are applicable selectively in these zones and there are restrictions on the workers to prevent unionizing. Government has relaxed labour laws and inspection rules to maintain and promote growth. Benefits too

are minimal, as are the wages. Further, more young single women are preferred as they are perceived to be more pliable and free of domestic responsibilities. Lack of accountability mechanism and special regulations ensure further exploitation of the women who work here⁹.

In India, about 70-80% of the workers in the electronic and fabric based manufacturing units in the EPZs are women. Dalit

women in all probability form a large number of the unskilled and low skilled workers in EPZs, involved in assembly operations and packaging. They work as casual or contract labour, in very poor and exploitative conditions¹⁰.

While uninhibited industrialisation has taken its toll of the

I don't understand the Govt. policies & initiatives. I am only worried that if I cannot bring some food today, my two sick children will die!



⁹K. Hemlatha, All India Convention of EPZ/SEZ Workers held in Vishakapatnam. http://pd.cpim.org/2002/july14/07142002_epz_convention.htm

¹⁰Rajni Tilak, Sana Das, Indian Dalit Women: Life after Liberalisation. <http://www.worlddignityforum.org/indiandalitwomen.aspx>

Source: CEHAT, Trapped into living: Women's Work Environment and their perceptions of Health, ed. Padmini Swaminathan

environment, globalisation and neo liberal trade practices like dumping of waste from developed to developing countries is a dangerous trend. In addition to households, huge amounts of waste are generated by hospitals and other industries. This not only affects the environment and impacts the health of the people but also causes great harm to the health of those who work with such waste – mainly the poorest of the poor and a majority of them women and children.

Food & Nutrition

Women play an important role in the production of food and manage the nutrition needs of the family but their own health and nutrition needs are ignored. Poverty, cultural norms regarding food intake and allocation of food within the household impact the nutritional status of women.

These practices begin early. Girls are breast-fed less frequently, for shorter durations, and over shorter periods than boys. They are weaned early, and may not receive sufficient quantities of supplementary food. The quality of food given to boys is usually more nutritious than that given to girls. This situation is worse in poor families or in situations of scarcity, which seems to be the general situation for a large number of people living in cities and villages¹¹.

Women, especially those who may be suffering from disabilities, women who have not given birth to a son, older women etc are particularly affected by inequitable food allocation.

According to the NFHS 2, 34% of the women between 15-19 years of age are already married. Marriage brings several changes in

¹¹ An Anthology on Women. Health and Environment: Nutrition and Agriculture.
<http://www.who.int/docstore/peh/archives/women/>

Towards the National Health Assembly II

the lifestyle of young women which add together to reduce her nutritional status, for example increased workload (both at home and on the farm), lack of rest and leisure, starting the ritual of fasting, and the expectation of early child-bearing. The food deprivation or nutritional inadequacy is more glaring with respect to puberty, menstrual cycles, pregnancy and childbirth. During pregnancy and lactation, for example, in many parts of India, meat, eggs and other high-protein foods are not given to women. In some parts there are restrictions on intake of water after delivery.

Adult women consume less nutritious food / nutrients as compared to men due the belief that women require lesser food than men as they work less. This is in spite of working longer hours and doing more strenuous work.

Food is also closely related to culture and communities, regardless of their class, prescribe several practices relating to food that are mostly imposed on women and affect their nutritional status. This social discrimination against young girls, women in nutritional matters exists despite agricultural growth and economic development.

Neo liberal policies have an adverse impact on the whole population especially women. Changes in cropping patterns, limited



Certain groups of women are discriminated in accessing adequate housing. Such groups often include victims of domestic violence, single women, elderly, women-headed households, those forcibly separated from their children, victims of forced evictions, indigenous and tribal women, ones with disabilities and women in conflict/post-conflict situations, refugees, migrant & domestic women workers, sex workers, and lesbian and transgenderd women having risk of becoming homeless, facing violence or suffering.

access to forests, and lack of purchasing power, inefficient public distribution system, and cultural practices are some of the major reasons for lack of food security, poor food intake, poor nutritional status among women, especially Dalit and Adivasis women, women in women headed households etc.

The availability and affordability of food for the poor and marginalised is closely linked with the public distribution system (PDS) in India. The system has been providing subsidised rations since 1964. Since 1977 however a Targeted Public Distribution System was introduced as a result of which the price has rapidly increased. Consumers were divided into two categories Above Poverty Line (APL) and Below Poverty Line (BPL), those who are APL could purchase through the PDS at the market price and BPL consumers were to pay only half. However the price was still beyond the purchasing power of the people falling in the BPL category. What made the situation worse was the decision of the Central Government in 2002, to reduce the number of persons eligible to get subsidized rations under the below poverty line (BPL). In Rajasthan alone 10 lakh families were to be removed from the BPL list¹².

In many rural villages and urban slums, the PDS system has been wrought with corruption. The ration through the public distribution system, is often not available and when it is available it is often found to be sub standard. Seventy two per cent of the rice and sixty five per cent of the wheat never reaches the people it is intended for¹³. As a result people are forced to buy from the market, pushing those who don't have money into a cycle of debt.

Many of these anti poor changes have been directly or indirectly linked to structural adjustment policies and globalisation, to reduce subsidies by cutting expenditure. Most nutrition interventions in developing countries continue to be designed primarily to reduce

¹² Gonsalves Colin. <http://www.righttofoodindia.org/data/gonsalves06pds.doc>

¹³ Suchi Pande. Ensuring Public Accountability Through Community Action 2005 Institute of Social Studies Trust, New Delhi, Background Note on Health in Urban Slums in Delhi. / <http://www.isst-india.org/PDF/Health%20in%20Urban%20Slum.pdf>

malnutrition among children. Even programmes which include women tend to focus on pregnant and lactating women. This approach limits the success of interventions since action to improve nutrition-related reproductive outcomes is most effectively implemented before women become pregnant, and preferably should

There are 4 common wells in our village but we have to walk 1 hour to fetch water for our families. Being Dalits we are not allowed to use those wells.



be undertaken before girls reach reproductive age. The different circumstances of men and women in developing countries affect women's nutrition, and it is necessary to take such differences into account when designing nutrition interventions.

Housing, water and sanitation

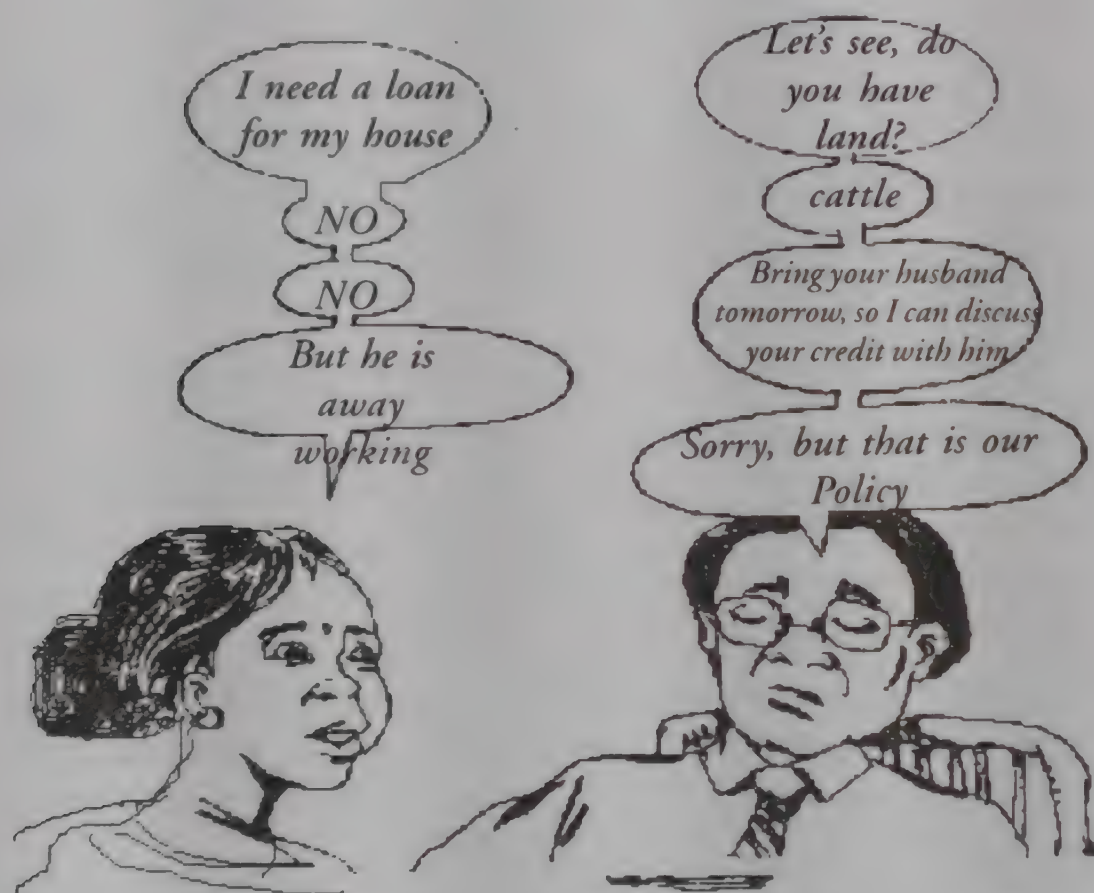
Women play the primary role of caregivers and spend more time in the home, taking care of children and family members and house work. A lot of women also do home based work, which has only been increasing due to casualisation of labour, and changes in the labour market with changes in global policies. This is a primary reason why issues of housing have a greater impact on women's health. Housing does not imply only the physical structure but includes social and community facilities, essential services and civic amenities like water, sanitation, waste disposal etc, and is also connected with livelihood. Absence of housing/homelessness or inadequate, poor

¹⁸ Miloon Kothari, ECONOMIC, SOCIAL AND CULTURAL RIGHTS, Women and Adequate Housing, Report by the Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard of Living, and on the Right to Non-discrimination

housing increases the vulnerability to disease, injury, violence, particularly for women

India has an estimated 2.3 million people who are homeless. Almost 70-80 percent of all refugees and those internally displaced, are women¹⁴.

Forced evictions have become a common phenomenon today and have an intense impact on the physical and mental health of women. It generally affects the poorest, the socially and economically most vulnerable and marginalised sections of society. Forced evictions, towards 'beautification of urban areas/cities', for example, have only further marginalised the poor and the women. The evictions have created 'ghettos' increasing already existing social inequalities and conflict. Such areas are neglected with little or no civic amenities



further compromising the health of those who live there. Most of the lands on which slums exist belong to the government or local goons and women often face violence in day to day survival. Women

are often unable to access civic amenities and are left to the mercy of local thugs and authorities who take no action.

In the rural areas too the situation is abysmal especially in the areas where marginalised communities - Dalits, Adivasis, and Muslims etc live. These areas are geographically/physically demarcated from the rest. Civic amenities like water, sanitation are poor or absent. Shortage of water, poor sanitation and inadequate sewage disposal, which are the nation's biggest public health problems, affects the poor, dalits, adivasis, especially women the most.

Social attitude towards women dictate how women should conduct themselves, often leading to increased need for privacy. In places where there are no toilets, baths or are not accessible, women have a very high incidence of health problems because they cannot use the open like everybody else. Also women's needs are rarely if ever considered, while resettlement plans are made.

Women spend a considerable amount of time carrying water from distant wells and other sources, and its shortage adds to the burden. The problem of non-availability of drinking water is still very acute, particularly for the majority of poor women. Available data indicates that only 56 percent of women have access to potable water supply

However, in rural and urban areas availability does not necessarily ensure easy access. This is further complicated by factors like caste and class. Even today, in many villages, girls and women from lower castes are not allowed to draw water from the wells of the higher caste people since it is believed that they will 'pollute' the water and often face violence as a result. Drinking water sources maybe far away from homes in rural areas. In urban areas water sources may be nearer but timing and flow maybe inadequate¹⁵. Women and girls being primarily responsible for collection of water, spend many hours a day, depending on the season and availability.

The dimensions of water pollution and scarcity continue to expand due to the present trend of globalisation marked by rapid

¹⁵ Sama, Tolakari-a beginning

industrialisation, changes in agricultural patterns, deforestation etc. The water tables in many parts of the country have been depleted due to indiscriminate commercial use of water for construction, industrial use etc at the cost of shortage of water for drinking, and domestic use. This trend is apparent in the rural areas as water resources are being used to supply/sell water to urban cities by private and government water suppliers.

In rural areas, scarcity of water has been documented as making class and caste distinctions more rigid. Scarcity especially for lower caste and poorer families may be caused by control of water supply by upper caste, rich men, who invariable control water supply although it is women who are normally responsible for collection of water. Women tend to respond to acute water

scarcities by limiting cooking, washing, cleaning, with serious implications for their health and the health of the family, community etc.

In this era of globalisation, some states have initiated new water policies and laws to make water 'state property' which can subsequently be privatised. Commercialising water to be sold for profit is disastrous especially in a country where water-borne diseases are amongst the most major causes of sickness and ill-health. An estimated 50,000 people, mostly women and children, die daily as a result of

Witch hunting, practiced in several states in India is rooted in Socio-economic factors: land-grabbing, property disputes, personal rivalry and resistance to sexual advances. In many cases, a woman who inherits land from her deceased husband is asked to disown the land by her husband's family or other men. If she resists, they approach the Ojhas (traditional village doctors) and bribe them to brand her a witch. This strategy of branding a woman a witch is also used against women who spurn the sexual advances of the powerful men in the community.

Towards the National Health Assembly II

poor shelter, polluted water and inadequate sanitation¹⁶.

Women's rights to adequate housing and health are violated by deeply entrenched patriarchal traditions and values, which dictate that wealth, property and land belong to men. Majority of women, because of low incomes, limited access to family land and property, may not be able to avail of loans for housing.

Various factors in the housing environment may influence health negatively – lack of civic amenities, or limited availability or accessibility of these, which are the cause of high incidence of health problems, in urban and rural areas. Other factors such as high levels of noise, poor indoor air quality, inadequate garbage storage and collection facilities, poor food storage and preparation facilities, temperature extremes and high humidity, overcrowding, poor lighting, inadequate or inappropriate construction material, building defects and pests may also affect health significantly. Violence against women can increase the chances of homelessness and fear of homelessness can make women want to continue to remain in situations of violence and exploitation. Violence as is well recorded has severe consequences for health¹⁷.

Violence

Violence against women ranges from physical, sexual and psychological harm in public or private domains. Women face different forms of violence throughout their lives. Violence against girls and women begins even before they are born. **The sex ratio bears witness to the impact of the discrimination and violence**

¹⁶ Miloon Kothari, ECONOMIC, SOCIAL AND CULTURAL RIGHTS, Women and Adequate Housing; Report by the Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard of Living, and on the Right to Non-discrimination

¹⁷ Miloon Kothari, ECONOMIC, SOCIAL AND CULTURAL RIGHTS, Women and Adequate Housing; Report by the Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard of Living, and on the Right to Non-discrimination

against girls and women.

Sex ratios have witnessed an alarming decline for children in the 0-6 years of age group and stands at 927 girls for 1000 boys even though there is a marginal improvement in the overall female ratio for the country as a whole (Census of India 2001). Between 1991 and 2001, in urban areas, the CSR declined from 935 to 903 and in rural areas from 948 to 934.

During infancy and in the growing years violence is perpetuated in the form

This is the beginning. My grandmother says I have to face every kind of negligence and violence at home, at work and on street till I die as I was born a Girl!!!

of infanticide, neglect of nutrition needs, education and healthcare, early marriage, sexual abuse, incest, physical violence. As adults women face violence due to unwanted pregnancies, domestic violence, sexual harassment in workplace and sexual violence including marital rape and 'honor killings'. Women are killed by their family members if they transgress the social norms by committing adultery, or are victims of rape, or in love with a person from another caste or religion, etc. Women, young and old, face violence through practices like Sati and witch-hunting.



In Bihar, for example, an average of 200 women is killed every year as witches¹⁸. In the case of widows, the lack of economic independence and security makes them particularly vulnerable to these atrocities.

Women with disabilities too, are especially vulnerable to violence, both from within the family and outside it. They are often abused and raped and also face other violations such as forced tubectomies and hysterectomies.

¹⁸ Radhika Coomaraswamy. The Varied Contours of Violence Against Women in South Asia, presented (2005) in Pakistan

Towards the National Health Assembly II

Just as women are not homogeneous as a category, similarly their experience of violence differs often in accordance with their various identities. Women face caste-based violence, communal violence, violence in conflict situations and violence of 'development' agendas. Violence against Dalit women has been increasing with increasing resistance against subordination, untouchability by the Dalit community in general and by women in particular. *In September 1999 a Dalit woman was dragged out of her home and pinned down by 15 men and both her hands were chopped off.*

Case study: Communal Violence, Gujarat

By now it was 6.30 in the evening. The mob caught my husband and hit him on his head twice with the sword. Then they threw petrol in his eyes and then burned him. My sister-in-law was stripped and raped. She had a three-month old baby in her lap. They threw petrol on her and the child was taken from her lap and thrown in the fire. My brother-in-law was also struck on the head with the sword and thrown in the fire. We were at the time hiding on the terrace of a building. My mother-in-law was unable to climb the stairs so she was on the ground floor with her four-year-old grandson. She told them to take away whatever money she had but to spare the children. They took away all the money and jewelry, and then burnt the children with petrol. My mother-in-law was raped too. I witnessed all this. Unmarried girls from my street were stripped, raped and burnt. A 14-year-old girl was killed by piercing an iron rod into her stomach. The mayhem ended at 2.30 am. Then the ambulance came and I sat in it along with bodies of my husband and children. I have injury marks on my both my thighs and left hand, which were caused by the police beating. My husband (48 % burns), my daughter (95 % burns) both died in the hospital after three days. The police was on the spot but they were helping the mob. We fell at their feet but they said they were ordered from above not to help. Since the telephone wires were snapped we could not inform the fire brigade.

Source: Jannat Sheikh, testimony to Citizens Initiative. *"How has the Gujarat massacre affected minority women? The Survivors Speak Fact-finding by a Women's Panel", Citizen's Initiative, Ahmedabad April 16, 2002.* <http://cac.ektaonline.org/resources/reports/womensreport.htm>

Gujarat was witness to systematic sexual violence unleashed against young girls and women during the massacre in 2002. Rape was used as an instrument for the subjugation and humiliation of a community. Barring a few, in most instances of sexual violence, the women victims were stripped and paraded naked, then gang-raped, and thereafter quartered and burnt beyond recognition.

Stop using me to prove
your power and
masculinity.



Women in conflict situations like Jammu and Kashmir and the North East region have struggled against Violence against them. The state actors like the army and the non state ethnic rebel groups have been in situations of conflict for several decades. Women in these areas experience violence on a day to day basis. In Kashmir, sexual abuse, harassment and rape are rampant, at the hands of both, the army as well as the 'militants'. Fear and insecurity forces the girls to drop out of school. The situation is similar in some of the states of north eastern region. Various other human rights violations are prevalent and women often bear the brunt.

Being witness to, subjected to violence has a diverse range of impacts on the woman's mental health. From being personally subject to brutality, to being a hapless witness of violence while it is unleashed on the community can have a deep impact on women's mental and physical health. Survivors of violence especially sexual violence, commonly feel fear, guilt, shame and anger. They may adopt strong defense mechanisms that include forgetting, denial and deep repression of the events. The trauma can result in minor depression, grief, anxiety, phobia, and somatic problems to serious and chronic mental conditions. Other impacts may also result in suicide.

Most violence stems from unequal power relationships, and the patriarchal male dominated set up has constantly sought to subjugate women and their rights. In the current context patriarchy has found an ally in the globalised world. Newer forms of violence have

Towards the National Health Assembly II

manifested themselves, but they are based on the age-old discriminations of the patriarchal society. The intensive propagation of contraceptive choices for women is one such instance. It absolves

Remember! Violence is not only restricted to the physical but also includes, neglect and denial of rights by the state or any other system or community, with regard to specific sections of the population



the male of responsibilities of birth control, and puts the burden of the same on women at the risk of her health. Therefore patriarchal forces if earlier offered her minimal options with regard to control over her body and reproduction, now in the

globalised world it offers her a range of “choices” of contraception, which place her health at risk. For instance, apart from condoms and vasectomies, all other methods target women. And men do not prefer either of the two options available to them, with reasons such as, inconvenience, lack of pleasure, fear of impotency. Initially the Injectable contraceptive Depo Provera was intended to be for men, but because of side effects like loss of libido, it was not promoted as one. However health consequences for women, which are more severe and painful, are ignored as being minor or ‘normal’¹⁹.

Before the advent of the technology, the strong son preference was evident in the practice of female infanticide and today the same bias is at work in the rampant use of technology for sex determination and subsequent sex selective abortions, and in pre conception sex selection techniques. The global manufacturers of the ultrasonography machines view India as a major market for their products, and this is not merely based on its diagnostic usage, but also its usage for sex determination.

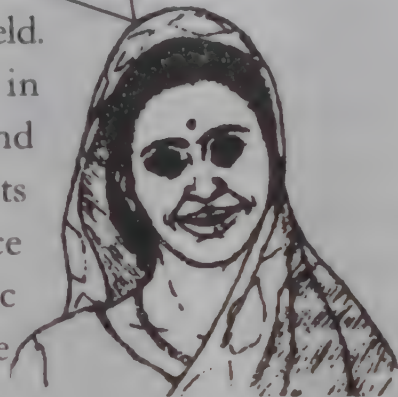
¹⁹ Sama Resource Group for Women and Health, ‘Unveiled Realities’-A study on Women’s Experiences with Depo-Provera an Injectable Contraceptive, 2003

Violence – A Public Health Issue

Over a period of time the understanding of what constitutes violence has also been broadened.

In this respect what is of concern is that while we are looking at violence on women as a health concern, we also see violence being perpetuated by certain health care mechanisms and globalisation and privatisation in this field. Therefore violence as a concern in women's health cannot be ignored and needs to be responded to. Despite its varied implications on health, violence against women has not gained the public health attention it demands. Since the health care is provided in a setting, which is a reflection of the larger society with its inherent prejudices and biases, the medical practice also tends to resonate and strengthen the biases. This gets reflected in the attitudes of medical professionals - predominantly male and largely middle class – who often see women patients as hysterical, and beyond reason.

The denial of appropriate medical care, irrational practices and unnecessary interventions on our body, hazardous and forceful sterilisation are few forms of violation of our health rights! There are many more that are rarely addressed in a society.



Often the health professionals either overlook the specific needs of victims of violence or show very little sensitivity in addressing the same. This silence of the providers can be attributed to their belief that violence is more often than not a 'personal' issue or a family matter. Time and space constraints and legal complications and procedures also deter doctors from addressing violence as a public health issue. Medical doctors thus usually remain confined to treating the injuries that are visible and get reported.

Towards the National Health Assembly II

While the denial and continuous neglect by the health system violates women's health rights, the medical community also actively perpetuates violence on women's bodies and health through irrational practices and unnecessary interventions such as cesarean sections, hysterectomies, routine episiotomies, etc. Women have reported rude behaviour and prejudiced attitudes of the staff while in labour, thus adding to their suffering. The hospital settings are found to be extremely depersonalised and inattentive towards women. On the other hand, in the case of the family planning programmes, they are made the prime targets.

Over time women's bodies have been over medicalised and treated as battlegrounds for unethical clinical trials, hazardous contraceptive technologies and invasive procedures with complete disregard about the effect these may have on their health. Very little or no information is provided to them about the risks involved and they are dumped without any follow up or monitoring. Many a times, sterilisation is offered as a necessary condition to women asking for abortion and no attention is paid to post-operative complaints.

The realities of women's lives reflected here clearly dictate the urgent need to recognise and acknowledge that women's health is largely dependent on their status and their productive and reproductive roles. Unless women's rights to be free from discrimination and violence, to have safe and fair wages, rights to food, water, adequate housing among others are not ensured, women's right to health will not be achieved. Access to quality healthcare is another important determinant of women's health. The follow section looks at the healthcare system and analyses the factors and reasons that limit women's access to health care.

Section II

Critical Analysis of Healthcare Situation

Unequal Distribution of Healthcare Resources in India

Healthcare resources in India are unevenly spread over different geographical regions, with huge gaps between rural and urban settings.

The ratio of hospital beds to population in rural areas is lower by fifteen times from urban areas. The ratio of doctors to population is about six times lower than that in the urban population. Government's expenditure per capita on public health is seven times lower in rural areas, compared to spending in urban areas.

Though the allocation on healthcare is 6% of gross domestic product (GDP), the state expenditure is merely 0.9% of the total spending.

The primary health centre (PHC), which is central to the public health system is increasingly becoming ineffective. A recent survey found that only 38% of all PHCs have all the essential staffs and only 31% have all the essential supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs (Table I & II).²⁰

DO YOU KNOW?

Only 17% of all health expenditure in the country is borne by the state, and 82% comes as 'out of pocket expenses' by the US. Such inadequate and unequal spending on public health is affecting the the public health system.



²⁰ 'Socio-economic Inequality and its Effect on Healthcare Delivery in India: Inequality and Healthcare' by Milind Deogaonkar, in Electronic Journal of Sociology (2004), cited in Sama- Dossier on Women's Right to Health for UGC through NHRC, 2006

Towards the National Health Assembly II

Lack of commitment by the Indian government to ensure universal access to healthcare facilities not only jeopardises the health of the people but also aggravates it by posing access difficulties. These access difficulties may be either due to geographical distance, socio-economic distance or gender distance²¹.

Geographical distance very often poses as the primary barrier to access health care. In a large country like India, people who live in

Table II: Health Services Personnel in the Existing Infrastructure and Actual Requirements (as per population) 2000-2001

Post	Actual Requirments	In Place	Shortfall (A)
1 Specialist per CHC			
Paediatrician	7415	440	94%
Physician	7415	704	90%
Gynaecologist	7415	780	89%
Surgeon	7415	781	89%
Only 1 Doctor per PHC			
Doctor	24717	25724	No shortfall
Midwife Nurse 1 per PHC + 7 per CHC			
Midwife Nurse/Nurse	44143/76622	27336	38% / 64%
Male MPW 1 per Sub Centre; ANM 1 per Sub Centre and PHC			
Male MPW	148303	71053	52%
ANM	173020	137407	21%
Health Assistant	24717	19927	19%
Lady Health Visitor	24717	19855	19%
1 per CHC + PHC			
Pharmacist	32132	21118	34%
Lab Technician	32132	13262	59%

Source: Quality of Health care: Public vs Private by Alpana Sagar in Background Papers for MFC Annual Meet 2006

²¹ 'Socio-economic Inequality and its Effect on Healthcare Delivery in India Inequality and Healthcare' by Milind Deogaonkar, in Electronic Journal of Sociology (2004). cited in Sama- Dossier on Women's Right to Health for UGC through NHRC, 2006

remote areas where there is either an absence of or very poor transportation facilities cannot even reach the nearest public health structure, and hence remain perpetually out of reach of the health system. On the supply side, equipping and re-supply of remote healthcare facilities is inadequate, which further dissuades people from using the existent facilities. The absence of adequate health personnel is another problem since the doctors and nurses do not have the motivation to remain posted in rural locations because of insufficient and ineffective support structures and facilities (like school for the children, transport etc). Geographical distance becomes more crucial for pregnant women who live in remote areas especially the tribal and contributes towards the higher maternal mortality among women. Geographical distances affect women with disabilities disproportionately and are unable to access health services. Even for general health problems the women cannot access a remote health centre because of their limited mobility.

Nearly half of the women (47%) live in a village that has some kind of health facility. 14% of women have to travel at least 5 Km to reach the nearest health center. The need of more health centers is clearly visible as per the table III. (see next page)

The **socio-economic distance** is due to economic barriers include cost of healthcare, social factors, such as the lack of education, lack of culturally appropriate services, language/ethnic barriers, and prejudices on the part of providers. All these factors lead to an inability to identify health problems and seek appropriate care on the part of poor women from marginalised communities. Health services are often not provided in Dalit areas in the villages. Majority of health providers belong to the upper castes and their attitude towards poor Dalit women is extremely discriminatory

Problem of accessibility is further stress by gender. Gender discrimination makes women more vulnerable to various diseases and associated morbidity and mortality. They are socially, culturally, and economically in subordinate positions, as compared to men.

Women are largely excluded from making decisions, have limited

Table III: Access of the health centers by ever-married rural women age 15-49 distance from the nearest health facility, India 1998-99

Distance	Health Facility					
	PHC	Sub-centre	Either PHC or Sub-center	Hospital	Dispensary/clinic	Any health facility
within village	13.1	33.0	36.5	9.7	28.3	47.
<5 Km	28.4	39.7	40.8	25.0	32.4	38.9
5-9Km	29.2	16.3	15.3	25.1	17.4	9.7
10+Km	28.8	9.6	7.0	40.0	21.7	3.9
Don't know/missing	0.5	1.4	0.3	0.2	0.2	0.2
Total %	100.0	100.0	100.0	100.0	100.0	100.0
Median distance	4.9	1.3	1.0	6.7	2.4	0.0

Source: NFHS II

access to and control over resources, have restricted mobility, and are often under threat of violence from different social structures of

The doctor of the PHC had refused to conduct my last delivery because I am an adivasi woman! This time I will go to nearby village to the old dai as I don't want to lose this child too.

family, community and the state. As a result of this perpetual secondary status, women are less likely to seek appropriate and early care for health problems, whatever the socio-economic status of family might be. This discrimination in accessing

healthcare becomes more obvious when the women are illiterate, unemployed, single or dependent on others. Thus despite the burden of ill health, the lack of support mechanisms and **gender related distance** leads to the exclusion of women from the healthcare system.

Access to healthcare is limited in situations of

Meena's Tale

Meena lived in Pushpavanam village by the sea shore in Nagapatinam district of Tamil Nadu. Her husband was a fisherman and he owned a "Catamaran". The family's economic condition was reasonable. Meena was his second wife. He was 40 years old when he asked for Meena's hand in marriage, she was 15. Her parents happily relented and got her married to him. Four months after the marriage, Meena was pregnant. To reach the health center from the village, one had to walk 8 kilometres on the sand/shore to reach the main road, from where buses were available. There was no one to accompany her to the health centre. Her husband was busy at sea. Meena was not comfortable going to the health center on her own. Girls and young women were not permitted to travel alone.

Pushpavanam village had never been visited by the village health nurse. Village elders and leaders had given a petition that the village needed a sub centre /a nurse. But who would pay attention to the needs of poor fisher folk.

Meena's first child was born dead. Two girl children were born one after the other and finally a boy was born. Everybody said the family's prayers had been answered. All deliveries took place at home. In the meantime Meena's health deteriorated. She was now just skin and bones. She often felt faint.

She was aware that she should go to the health center for treatment but the situation at home was not very good. As she was the second wife, her husband's relatives did not even speak with her. She was treated as an outsider, with enmity. She heard rumours about her husband having affairs with other young women.

When the boy was only 4 months old, she became pregnant. She was afraid that her son's health would be affected if she had another child so soon. She decided to go for an abortion and went to an old lady who performed abortions.

No one else was aware of it. After a week she developed a fever due to infection. Meena did not reveal anything to anyone. Her condition worsened. Her husband was at sea, people at home did not know what to do. They were not willing to take Meena to the health center without asking her husband. After all it would mean a lot of expenses. Meena experienced a lot of pain and died the same night. She was 26 years old.

Source: Rural Women's Social Education Centre, TN, Training Manual for Community Based Organisations

communal riots or conflict. In such situations geographical and gender

Towards the National Health Assembly II

related distances impact women's access to healthcare.

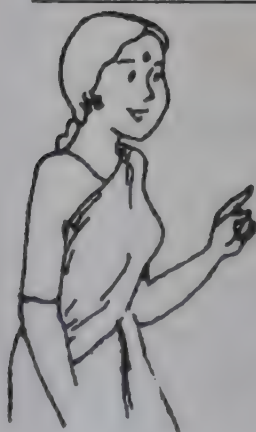
Apart from the above reasons of inaccessibility, women are frequently dissatisfied with the quality of government services they receive, for reasons that include the cost of services and drugs, rude and improper behavior on the part of health staff, staff shortages, timings of the health facility, lack of supplies and drugs, and long waiting time to see a doctor. Because of cultural constraints, women are not encouraged to consult male health providers and the non-availability of female doctors, nurses, and midwives affects their use and choice of health services. Women more often than not wish to be accompanied and will rarely go alone to the health facility. Women are also expected to get permission from their husbands or other members of the household to go for health services.

On the other hand unsuitable accommodations in rural areas,

lack of support services affects the decreasing number of female health care providers in rural areas.

Recent studies of poverty in 12 villages of Rajasthan and 20 villages of Gujarat show health costs as the single most important reason for households falling into poverty in the last 25 years.

Globalisation, Privatisation and Women's Access to Healthcare



Moreover shifts in policy directions and principles of competition and privatisation are creating a capital intensive and curative care rather than preventive health care services. The profit oriented corporate health care services with its urban, elite and male bias has not only given rise to unethical practices in terms of irrational diagnostic and screening tests, high curative costs etc, it will also reduce the concentration of trained medical practitioners in the public sector.

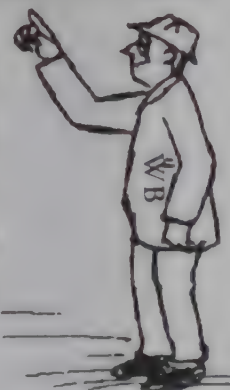
²² JSA Policy Brief 2000, cited in Sama- Dossier on Women's Right to Health for UGC through NHRC, 2006

especially in rural areas". These processes have lead to further impoverishment of the poor in general and women in particular.

Against this composite picture of heightened inequality in health access, there were attempts by donors to promote health sector reforms through Structure Wide Approaches (SWAPs) as a policy initiative, it failed to counteract the decline in access to public health services, reduce costs, or provide a firm basis for the paradigm changes. For example, the RCH programme depends for its effectiveness on the public health infrastructure of sub-centers, PHCs and hospitals, as well as staffing, logistics and management inputs from the public health system. This system went through major negative changes during this period because of selective primary health care approaches at the behest of global powers. In the entire period, the health sector was simultaneously undergoing the direct and indirect effects of structural reforms in the overall economy. Real expenditures on public health stagnated, accompanied by infrastructural decline and introduction of user charges. Perhaps the most significant increases in health costs came from the rapid liberalisation of the pharmaceutical industry resulting in sharp increases in drug costs. These spiraling costs have had a significant impact on access. According to the National Sample Survey, the importance of 'financial reasons' for not treating illness has gone up sharply.

Now, not only the private sector health services but also public health services are more utilized by the better off. Overall, because of the continuing weaknesses of the public sector health services, and relatively low cost differentials between public and private health providers, over 70 per cent of outpatient care is provided by the private sector. However, partly because of greater cost differentials, only 40 per cent of inpatient care was handled by the private sector.

Healthcare as a commercial activity results in denial of right to health and undermines state's responsibility in providing basic health care to poor, especially women.



Towards the National Health Assembly II

In recent years, India has seen a resurgence of many infectious diseases like Malaria, Encephalitis, Kala Azar, Dengue etc. Simple curable diseases like diarrhea, dysentery, acute respiratory infections and asthma also take their toll due to a weak public health system.

This systemic failure of the public health system has been defined by many activists as a form of structural violence, a violation of both individual and group rights which leads to following:

- A kind of differentiation of the health care system- one for the rich and other for the poor leading to further polarisation of the two groups
- Declining or stagnant budgets, deterioration of quality of care in public health system that has lead to *systemic weakening*
- Emergence of a exploitative, profit making private sector that the poor can hardly afford, leading to further indebtedness
- Negative impact of Globalisation-Liberalisation-Privatisation policies on various social sector services
- Trend towards a gradual withdrawal of the state from investments in public health services, selective primary healthcare provisions
- Proliferation of an unregulated private medical sector: The failure to support public sector personnel to perform their duties in the skeleton comprehensive programs inevitably created a very big 'market' for the private sector. This is an increasing burden on the poor who are at the receiving end in this scheme of things, making treatment of diseases as the second most common cause for rural indebtedness after dowry²³.

Under various states Health Systems Development Projects, the World Bank has been slowly re-organizing health sector in the whole country in the name of alleviating poverty. India is being exhorted by the international banks to reduce public expenditure in health through increasing privatisation. With a 20 percent reduction in the allocation of health services in the union budget after the conditionalities laid

²³ Surveys by NSSO 1992, NCAIR 1992 on Pattern of Utilisation of Medical Institutions- Imrana Qadeer, Kasturi Sen, K.R. Nayar (ed) Public Health and the Poverty of Reforms 2001.Sage pp 46

down by the WB/IMF, the marginalisation of the public sector and the expansion of private sector continued.

Health and health care inequities are increasing, and are deeply unjust — a just health system would ensure that all citizens, irrespective of caste, class, gender and sexuality would receive basic quality health care in times of need. The lack of commitment on the part of the State is increasingly impoverishing the already poor masses of the country- some of the major reasons are:

- Forty percent of hospitalized people are forced to borrow money or sell assets to cover expenses (NSSO Department of Statistics, GOI, 42nd & 52nd Round).
- The pharmaceutical industry is rapidly growing, yet only 20% of the population can access all essential drugs that they require. This is a result of the deregulation of the pharmaceutical industry, lax price controls on drugs. There is a proliferation of brand names with over 70,000 brands marketed in India, but the 2002 Drug policy recommends that only 25 drugs be kept under price control (compared to 343 drugs under price control in 1979). As a result, many drugs are being sold at 200 to 500 percent profit margin, and essential drugs have become unaffordable for the majority of the Indian population. Only 49% of the population had sustainable access to affordable essential drugs in 1999-2001²⁴.

Over 2 crores of Indians are pushed below the poverty line every year because of the catastrophic effect of out of pocket spending on health care !



²⁴ India Women's Watch (2006) From Shadows to Self NGO Country Report 2005: Beijing +10

Effect of TRIPS on Drug Policy, Increasing Prices, Role of Private Sector in Healthcare & Implications on Women's Health

Price regulation in the pharmaceutical sector is an important instrument of public policy of promoting equity in access to health care (see Section V for more details).

The Pharmaceutical Policy (PP) 2002 of the Government of India wanted to dilute drug price control by suggesting criteria for price control that will reduce the basket of price control to a bunch of irrelevant 30 or so drugs. The kinds of drugs that would be left under price control are mostly irrelevant to public health. Even the Drug Price Control Order of 1995 conspicuously omitted drugs for anemia, diarrhoea, the majority of drugs for tuberculosis, hypertension and diabetes, and all drugs for cancer.

The Trade Related Intellectual Property Rights (TRIPs) agreement has influenced the drug pricing and policy in a negative way for India. The issue of drugs has shifted from the realm of health to the realm of trade – a situation made worse by the rise of multinational pharmaceuticals who are trying to control and own knowledge in the name of intellectual property rights²⁵.

About 65% of the Indian population lack access to essential life saving medicines despite India being recognised as a global drug manufacturer.



In reality, the provisions of TRIPS undermine some of the very processes that helped India become one of the leading countries in drug manufacturing with some of the lowest prices in the world. The effect is exemplified in the attempts of the government to reformulate the pharmaceutical policy and amendment of the Indian Drug and Cosmetics Act to reduce the number of drugs under price control, and make space

²⁵ Srinivasan and Shiva (2002) 'Medicines and Health Care: Women's Perspective' in Renu Khanna, Mira Shiva & Sarala Gopalan (ed) Towards Comprehensive Women's Health Programme and Policy SAHAJ for Women & Health (WAH)

PIL Against Drug Pricing

A series of supportive affidavits have been filed in the Supreme Court in Sep 2003 by LOCOST, Jan Swasthya Sahyog (JSS), All India Drug Action Network (AIDAN) and the Medico Friend Circle (MFC) questioning the wisdom of the criteria for drug price control in Pharmaceutical Policy 2002 (PP-02). It is our submission that the policy will increase the price of medicines and therefore have a long-term effect, for the worse, on the health of people, especially poor people. The related SC order of 10/3/2003 says, "We direct that the petitioner shall consider and formulate appropriate criteria for ensuring essential and life saving drugs not to fall out of price control..."²⁶

A new policy has come out in 2006 out of which only Part 1 has been released. Part 2 has to do with price control and the new criteria are not yet known.

This litigation is also occurring at a critical juncture where India's state of public health is still grappling with old diseases while new ones like HIV/AIDS, diabetes and cardiovascular problems have got added on to the disease burden. Complicating this issue is the product patent regime of WTO/TRIPS effective from Jan 2005.

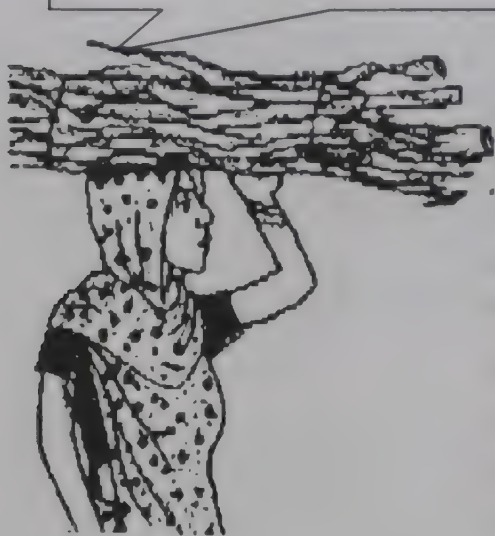
for clinical trials, respectively, in the name of liberalisation. For India it would mean wiping out the Indian public sector, private sector, small scale sector and overpricing of a large number of essential and life saving drugs and the already vulnerable population, especially poor women, be exposed to the unethical experimentation by the drug companies²⁷. For women, who form a disproportionate number of the poor, high prices of drugs implies reducing household expenditure to pay for life-saving medicines. This effectively excludes the poor and denies them access to healthcare and essential life saving drugs.

Thus, when we talk of health care services, it is important to not only talk of inadequacy of but an insensitiveness to understand women issues in general and health issues in particular. This is so because the

²⁶ LOCOST/JSS (2004) Impoverishing the Poor: Pharmaceuticals and Drug Pricing in India. Vadodara/Bilaspur, cited in Sama- Dossier on Women's Right to Health for UGC through NHRC, 2006

²⁷ Sama- Dossier on Women's Right to Health for UGC through NHRC, 2006

I don't have time to understand globalisation, TRIPs etc! I just know that we should all receive basic quality health care irrespective of our caste, class, gender and sexuality at a minimum affordable cost so that nobody is denied of it in my village.



of women as a 'group' often becomes problematic due to the differential treatment that single, lesbian, deserted women receive. Here, it would not be out of place to even talk of the differential treatment that mental-health patients and victims of violence face. Added to this the existing inequalities arising from caste, class and the low status of women in general determine

women's access to healthcare²⁸.

government planners, medical personnel, who 'treat' women, do not share the same world view with them and hence often find their complaints as 'vague' and 'fancy story-telling.' Moreover, to talk

²⁸ Sama - Paper on Women's Right to Healthcare as a Fundamental Right

Section III

Consequences for women's health

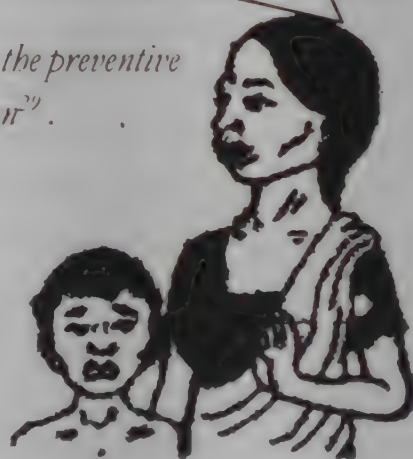
The discrimination and violence that women face in their homes, in society, has extremely negative consequences for their health. This is further compounded by lack of gender sensitive health planning and implementation, which ignores the realities of women's lives. It is evident from the earlier sections that women face discrimination in access to resources like food, water, appropriate housing, throughout their lives. The burden of work and the environment that they live in particularly affects their health. This section looks at some of the resulting health problems.

Morbidity and Mortality

As admitted in the national health policy, *the morbidity and mortality levels in the country are unacceptably high. These unsatisfactory health indices indicate the limited success of the public health system in meeting the preventive and curative requirements of the general population*²⁹.

A district study in Maharashtra showed that reproductive problems, urinary tract infections, aches and pains and weakness made up 47% of all reported morbidity³⁰. Maternal morbidity related to pregnancy, abortion and childbirth is also exceptionally high.

Due to our low economic status, ignorance and limited access to nutritious food, we suffer the highest rate of iron deficiency anemia which becomes acute during pregnancy! Doctor didi said that this is one of the main reasons of poor health.



²⁹ National Health Policy 2002 in <http://healthmanioir.nic.in/NationalHealth2002.pdf>, cited in Sama- Dossier on Women's Right to Health for UGC through NHRC, 2006

³⁰ Gopalan and Shiva (2000) National Profile on Women, Health and Development

Lack of appropriate care during pregnancy and childbirth, and the inadequacy of services for detecting and managing complications, explains most of the maternal deaths. Nearly 50 lakh women suffer ill health due to pregnancy related complications alone. According to a study, 37% of all pregnant women in India receive no prenatal care during their pregnancies.



The resulting chronic state of anaemia coupled with poor health care for women underlie the high morbidity and mortality in Indian women. “In India 1 out of 3 women in the age group 15-49 is undernourished as per the BMI” (NFHS II 98-99).

It is probable that anaemia among women accounts for a significant loss of productivity, and therefore of family welfare, in developing countries. Iodine deficiency disorders are of particular concern since they can result in severe negative reproductive outcomes for both mothers and infants.

Significant proportion (17%) of girls between 13-19 yrs gets married and commences child bearing³¹. Due to the unmet need for contraceptives and the lack of choice, information and/or decision-making power in contraceptive use, women tend to have closely spaced pregnancies. Some 37 percent of births occur within two years of the previous birth, endangering both the health of the mother and the survival of the infant. Research has shown that numerous pregnancies and closely spaced births erode a mother's nutritional status, adversely impacting the pregnancy outcome (e.g., premature births, low birth-weight babies) and also increase the health risk for mothers³².

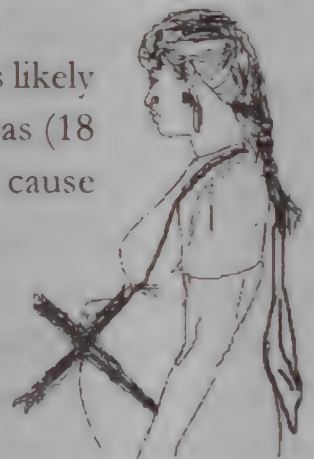
³¹ NCW Report on Status of Women in India, 2002

³² Jejeebhoy and Rao, 1995, cited in Sama- Dossier on Women's Right to Health for UGC through NHRC, 2006

India accounts for the second highest maternal mortality in the world³³. The figures are on a consistent rise, with National Family Health Survey (NFHS) II indicating an increase from 424 deaths per 100,000 live births in 1991 to 540 in 1997-98 and have remained stagnant till 2000³⁴. In numbers, this translates to one woman dying every five minutes primarily from sepsis infection, hemorrhage, eclampsia, obstructed labour, abortion, and anaemia. However, there are wide differences between estimates from Surveys, National Registrations Systems, and individual researches, all indicating a much higher figure. Moreover, in India, wide disparities exist within states, among specific communities and geographical regions. With improved antenatal care and institutional deliveries, some of the Southern states indicate a figure of 115 (TN), 198 (Kerala), while the north presents a bleak picture with MMR ranging between 707 and 367 (NFHS II).

Despite a Medical Termination of Pregnancy (MTP) Act in place since 1971, an estimated 4-6 million illegal abortions occur every year. While, 6-9% of these occur in adolescent girls, 16% are women between 20-34 years.

Moreover, women in rural areas are much less likely to receive prenatal care than women in urban areas (18 percent and 42 percent, respectively)³⁵. This is a cause of great concern as these deaths are preventable with improved attention to the nutritional needs of the girl child, right from early childhood and access to health care - particularly essential and emergency obstetric care, skilled birth attendant, ante natal and proper postpartum care. Not only pregnancy and childbirth continue to be potentially hazardous to women, early marriage, frequent and repeated childbearing and discrimination faced



³³ <http://www.infochangeindia.org/womenlbp.jsp>

³⁴ World Health Report 2006 See <http://who.org>

³⁵ IIPS, 1995 in Sarala Gopalan and Mira Shiva National Profile on Women, Health and Development 2000 VHAI, Delhi

Towards the National Health Assembly II

throughout the life cycle results in adverse health outcomes like RTI/STIs, uterine prolapse etc.

The poor health status among women is further compounded by their socially and economically disadvantaged positions as individuals of certain communities. For instance, *Dalit* women are **one and a half times** more likely to suffer the consequences of chronic malnutrition (stunted height) as compared to women from other castes. Children below 3 years of age in scheduled tribes and scheduled castes are **twice as likely to be malnourished** than children in other groups³⁶.

Unsafe abortions account for 9% - 17% (as per some studies by NGOs) of maternal deaths and result in several other morbidities.

2. Communicable Diseases

In addition to the poor nutritional status, maternal and perinatal ill health, communicable diseases including Malaria, Encephalitis, Kala Azar, Dengue, Leptospirosis, etc., contribute significantly to the heavy burden of disease faced by women.

Tuberculosis- It is one of the biggest killers of women in general and of women in the reproductive age group in particular³⁷. The transition from infection to the disease and its implication is rooted not merely in the biology but in the environmental, social and material conditions of living when women get infected, they are either sent back to their parental home for treatment or isolated. Non-pulmonary TB, namely genito-urinary TB is usually difficult to diagnose and even when diagnosed, remains untreated. This can cause infertility that has severe implication on women who are invariably left ostracized and isolated. Women fail to obtain quality care in the absence of a support system at home and lack of decision-making power in the utilisation of financial resources.

Malaria- that staged resurgence in the 80's before stabilizing at a

³⁶ Bang, et al. 1989 in Gopalan and Shiva 2000.

³⁷ www.who.int/inf-pr-1998/en/pr98-40.html

Lack of sanitation facilities, garbage storage and disposal cause contamination of water bodies. In addition to this, indiscriminate use of pesticides and chemical fertilisers in irrigation, and discharge of untreated sewage, waste water and industrial effluents has resulted in the contamination of many rivers, ponds, tanks and streams. This poses a major threat to women's health. A number of skin diseases and new ailments resulting from chemical pollution are on the rise.

high annual prevalence of nearly 2 million cases - affects women in various ways. Repeated attacks of malaria, especially falciparum malaria in already anaemic women results in worsening of anaemia. Pregnant women with malaria are known to have high incidence of abortion, premature labour and delivery, stillbirth and low birth weight babies and when inflicted with falciparum malaria can present with hypoglycemia (fall in blood sugar) - a fatal condition in the absence of prompt attention. They also face higher risk of death as Primaquin, which is essential for radical treatment of malaria is contra-indicated for pregnant women³⁸. Over the years, the incidence of the more deadly p-falciparum malaria has risen to about 50% of all malaria cases resulting in a high incidence of malarial deaths.



Leprosy- 58% of the cases recorded in the world comes from India³⁹. Like TB, Leprosy presents itself not only as a medical disease but is associated with immense psychological trauma and social stigma. Women inflicted with leprosy most of the time face desertion. Ironically, infliction of leprosy has been accepted as a ground for obtaining divorce by the legal system that intensifies women's vulnerability.

Similarly, common water borne infections -gastroenteritis, cholera,

³⁸ IIPS, 1995 in Sarala Gopalan and Mira Shiva National Profile on Women, Health and Development 2000 VHA1, Delhi

³⁹ ibid.

Towards the National Health Assembly II

some forms of hepatitis - continue to contribute to a high level of morbidity in the population. Crowded, cramped housing conditions, for instance, facilitate transmission of diseases including tuberculosis, influenza, meningitis, diarrhoeal diseases, measles and has also been associated with domestic violence, psychosocial problems, and accidents.

In addition, the 80's saw an increase in mortality through life-style diseases - diabetes, cancer and cardio-vascular diseases.

HIV/AIDS- Another extremely virulent communicable disease that emerged after the declaration of NHP in 1983, and significantly impacted the public health scenario and discourse is HIV/AIDS. A

Are you mad? How can I ask my husband to use condom?



decade after the first HIV case in the country was detected in 1986 in Chennai, there are approximately 5.20 million infected population. Of these, women account for about 40% of the infections⁴⁰.

Despite the alarming growth of the epidemic, most women in India have little knowledge of HIV/AIDS. The woman is either unaware of the possibility of contracting the illness through sexual relations with her husband/ partner, or unable to negotiate the precautions.

Most women do not have the right to say 'no' to sex in a marital relationship or even the capacity to negotiate condom use. Family planning practices in a state such as Kerala (often quoted as a comparatively better state in terms of health indicators) reveals that married couples usually do not use any family planning methods until the desired two children have been had⁴¹. At this point the woman undergoes sterilisation.

⁴⁰ NACO 2006 Estimates: www.naco.org, cited in Sama- Dossier on Women's Right to Health for UGC through NHRC, 2006

⁴¹ Sen, Gita Whither Women's health <http://www.india-seminar.com/2004/537/537%20gita%20sen.htm>, Sama- Dossier on Women's Right to Health for UGC through NHRC, 2006

The increasing incidence of heterosexual transmission in a context where women's sexual rights are violated both within and outside the family is indeed a disturbing trend. The recent statistics on the growing number of women affected by HIV around the world throws light on a significant dimension of the epidemic - the spread of HIV and its links with inequitable gender relations. It is this 'feminisation' of the epidemic that demands special attention. Added to this, the attached stigma and the reality underlying women's health where they are socialized to hide their ailments or not seek treatment on time keeps women out of the range of any treatment that could make a difference. In case of HIV/AIDS this lack of timely intervention can prove fatal.

Rising concerns about HIV/AIDS have certainly generated greater willingness to tackle awareness about sexuality, adult and adolescent sexual behaviour, and complex issues of medical ethics. Furthermore, the spread of HIV/AIDS is likely to stretch the capacity of public health infrastructure to meet women's health needs.

Work Related Health Consequences

The most common occupational hazard for women probably is overwork. Women have the complete responsibility of managing their household, and even if they are employed outside, it does not relieve any burden of these domestic chores.

The responsibility of collecting huge amounts of water for drinking and other use for the entire family results in women suffering from constant backaches, spinal problems, worn out feet and general



The problem of the reproductive tract, prolapse of the uterus, miscarriage, menstrual disorders, abortions, still births, anemia & muscular problems are a host of other health problems that emerge due to the sheer burden of work that women are compelled to bear.



discomfort. Permanent damage to women's health directly attributed to carrying water has been documented — among them spinal and pelvic deformities, and degenerative rheumatism. More immediate problems include exposure to water-borne diseases, chronic fatigue and the threat of miscarriage for pregnant women. Moreover,

collecting water especially in situation of scarcity multiplies women's work burden and causes tremendous mental strain for women. Collection of water in such situations also leads to arguments and occasional fights. For instance, women in the urban slums of Mumbai have cited water as a cause of local riots.

At the workplace women's health may be threatened by chemical, noise, lifting of heavy weight, physical risks, mechanical risks and many social risks too. There are problems of violence, sexual exploitation and harassment at the workplace. Some common health problems related to the informal sector are, problems associated with posture. Much of the work involves, constant bending and stooping for long hours, joint pains and body aches etc. are very common.

Also women are engaged in work with a lot of hazardous

materials, inhaling, smoke and other chemical fumes in some manufacturing units. Due to mining and exposure to radioactive materials due to lack of protection by authorities, women have been experiencing increasing mis-carriages, birth defect, skin infections, menstrual disorders, thalasemia and cancer. Women are often dependent on such employment for their survival and are unable to avoid such harm to them nor are they prepared to hold accountably those who are guilty of flouting safety regulations.

Many of the factories or units that employ women also do not have sufficient lighting or toilets. Women working under such conditions are more prone to urinary tract infections. Women work for long hours in these units, often consuming as little food and water possible, so that they don't feel the need to use the toilet⁴².

A study⁴³ in a rice-growing belt of coastal Maharashtra found that 40 percent of all infant deaths occurred in the months of July to October and a large number of cases were either premature or stillbirths. It was concluded that squatting for long periods of time during rice transplanting months is one of the major cause for this.

The constant exposure to fertilisers and pesticides has softened my hands and feet. I have developed rashes on my body too. I have severe headache and backache too every night after going back from the field



Dalit women and women, who are a part of the urban poor, are forced into working in garbage dumps, rag picking, cleaning dry toilets, etc. They become vulnerable to many viral infections, body sores that do not heal due to repeated exposure to unsanitary conditions. The adverse health effect of pesticide exposure includes

⁴² http://pd.cpm.org/2002/july14/07142002_epz_convention.htm

⁴³ Coonrod, Carol S. (1998) 'Chronic Hunger and Status of Women in India' <http://www.thp.org/reports/indiawom.htm>

Towards the National Health Assembly II

For women engaging in agriculture, cash crop production of fruits, vegetables and flowers involve exposure to toxic chemicals.	
Occupations ¹	Health Problems
Manual Agricultural Workers Postural problems; exposure to dusts and chemicals; unguarded implements; working barefoot.	Generalized body ache; aches in calves, hips, back, legs and shoulders; nasal catarrh; irritating coughs, irritation of the respiratory system; respiratory allergies; respiratory tract infections; tightness of chest; pneumoconiosis; cutaneous allergies; skin irritation; rashes and pruritus; mycosis; eye irritation; paddy keratitis; paronicia; fungal infection in feet; eczema; osteomyelitis of fingers; accident related health problems; Pesticide related-poisoning, intestinal respiratory and neurological disorders, nausea; vomiting, abdominal cramps, diarrhea, cough, headaches, vertigo, blurred vision, muscular twitching, convulsions; loss of reflexes; disturbance of equilibrium; jaundice; coma and ultimately death may result from respiratory arrest. Gynecological - Abortions, pre mature deaths and still births; high rate of neo natal, infant and maternal mortality
Quarry Workers (chrome) Exposure to high temperatures; lack of eye protection.	Heat strokes; severe eye problems as chips of alloys fly into the eyes.
Construction workers Heavy workload; unsafe noise levels; exposure to dusts and chemicals; accident-prone working conditions; contract labour).	Physical stress and strain; skeletal defects; numbness of hands and fingers; loss of hearing; stress; high blood pressure; muscular pain; intestinal problems; gastroenteritis; respiratory problems; asthma; silicosis; asbestosis; skin disease; heat cramps and sun burns; serious accident injuries, deaths; spontaneous miscarriages; high rate of infant mortality; a feeling of isolation and rootlessness
Ready-made Garments workers Postural problems; heavy workload.	Postural problems-back, especially low back pain; eye problems, anaemia; leucorrhoea; urinary tract infections.
Home based house workers Exposure to dust, fumes, fuel smoke, chemicals in household products, possibility of accidents, heavy work load, drudgery, postural problems, mental tension	Cough and expectoration; bronchitis; emphysema; irritation of eyes, nose and throat, skin wounds, skin reactions, eye diseases, physical pain, exhaustion, anaemia, hastening of tumor, carbon monoxide toxicity; impaired foetal development; severe depression; low self-esteem

poisoning, cancer, skin diseases, abortions, premature births, and malformed babies.

For women engaging in agriculture, cash crop production of fruits, vegetables and flowers involve exposure to toxic chemicals.

The chart on previous page illustrates some of the occupations and their related health implications on women.

¹ Shramshakti - part of the National Commission on Self-employed Women and Women in the Informal sector, Chapter 6 - Occupational Health

Mental Health

Mental health problems of women are rarely discussed. Approximately 15% of all women suffer from mental illnesses against 11% of all men⁴⁵. Samples from psychiatric surveys in rural/urban, north/south Indian communities done between the late 1960s and 1990 revealed 1.3 percent of women as diagnosed of Severe Mental Disorder (SMD) and about 10-11 percent women as diagnosed of Common Mental Disorder (CMD)⁴⁶. There is a strong linkage between gynecological morbidity and CMD. About 12-15 percent women report pre-menstrual distress. Post partum depression is a common reason for a significant number of women who require intervention⁴⁷.

Mental health of women is impacted simply by way of their day-to-day survival. The burden of work, the multiple roles that they have to play – within the house and outside it causes tremendous pressure and anxiety. Mental health is affected by increasing poverty, discrimination and violence.

Globalisation has had a very negative impact on mental health with rising unemployment, poverty, lack of access to resources, healthcare, and overburden of work, violence and the sheer struggle to survive. Suicide attempts are reported to be higher amongst women. All these are indicative of the various pressures she is under.

Majority of women in this asylum are labeled as mentally ill by their families, either to get rid of unwanted spouses, extraction of dowry or usurping property. Some are punished for challenging prevalent social norms.



⁴⁵ Davar, Bhargavi V. (2002) 'Dilemmas of Women's Activism in Mental Health' in Renu Khanna, Mira Shiva & Sarala Gopalan (ed) Towards Comprehensive Women's Health Programme and Policy. SAHAJ for Women & Health (WAH!), as quoted in Sama- Dossier on Women's Right to Health for UGC, through NHRC.

⁴⁶ *ibid*

⁴⁷ *Op cit* (Chandra 2001)

However, the infrastructural requirement in government hospitals for mental health treatment is poor. Allotment of beds for women in Government hospitals is far less than that for men. There is also a lack of clinical psychiatrists who can understand the socio-economic and cultural constraints and realities of the women as the major causes of mental health problems and thereby handle them sensitively. This absence restricts women's accessibility and willingness to seek medical care. While inadequate mental asylums, mental health beds and gender-sensitive psychiatrists continue to be a problem, the Mental Health Act (1987), which was meant to empower, is very often misused against her¹⁸.

Studies on the mental health aspects of violence, natural disasters and catastrophe, displacement and rehabilitation have been inadequate and lack a gender perspective. However, there is a gradual recognition of these inter linkages and institutions like Tata Institute of Social Sciences, Mumbai and National Institute of Mental Health and Neurological Science, Bangalore are undertaking studies to understand the impact of the trauma on the psyche of victims.

Health Consequences of Violence

The impact of these various forms of violence that women face, have a major stake in their ill health. It ranges from physical and mental health problems like lacerations, fractures, chronic pain, gynecological disorders, unwanted pregnancy, STIs, irritable bowel syndrome, asthma, depression and trauma, self injurious behaviour, low self-esteem, sexual dysfunction, post traumatic stress, etc., to fatal outcomes like suicides and homicides and permanent disability, all of which bring about intense suffering and ill health to a large section of the female population. ***Domestic violence is often counted as a significant cause of disability and death among women of reproductive age in India.***

¹⁸ Gopalan & Shiva (2000) National Profile on Women. Health and Development

According to a community and hospital based prospective study done in Maharashtra in 1993-1995, almost 16% of deaths in pregnancy were caused by domestic violence. Another study in Mumbai examining the emergency police register of the Casualty department in a public hospital revealed that 23% of women brought to the casualty were there due to domestic violence. Victimization of women by violence has its definite links to mental health. Her multiple subordinate identities and the repression that goes with it make her vulnerable to a psychological strain.

GOD SAVE ME !
1 in every 5 women
admitted in hospital
casualties are victims of
domestic violence



Health Consequences of Pollution & Environmental Degradation

Women and children are constantly exposed to various respiratory illnesses due to inhalation of dust particles and become victims of skin diseases, experience malfunctioning of various sensory organs, which has a long-term impact on their reproductive health. Noise and dust pollution affects women the most during pregnancy. The most common diseases suffered by people due to the dust from the coal mines are tuberculosis, cough and cold, malaria, skin diseases, diarrhoea, staining of teeth, joints pain, arthritis, lethargy, etc.

Further, the effects of chemicals and radiation from the ores have direct impacts on the women's health. For example, one of the most serious impacts has been the suffering of women living in the proximity of uranium mines in Jaduguda (Jharkhand) where radiation levels are scientifically proved to be above permissible limits and where there is a direct correlation between the reproductive and health problems of women to that of radiation from uranium. This causes

large numbers of miscarriages, the birth of physically and mentally deformed children, deaths and terminal illnesses like leukemia and thalassemia⁴⁹.

Communities surrounding mine-sites are forced to consume the contaminated drinking water from sources like rivers, streams, wells and bore pumps due to ill-treated or non-treated chemical wastes

Depressive disorders are found to be 2/3rd times more common amongst women than men. It is a leading cause of ill health and death. Gender based violence demands priority attention from the health system.



and debris by the mining companies, which seep into the ground water and soil. Women in particular are more susceptible to water pollution due to the role they play in the family, which involves contact with water sources for performing the household chores like collecting water, washing clothes, utensils and bathing children.

For example, the Chromite mines in Orissa have caused severe health problems due to the contamination of rivers and the causes marked irritation of the respiratory tract, nasal septum ulcers, and also causes irritant dermatitis rhinitis, bronchospasm and pneumonia. A study revealed that chromium has entered the food chain and has been found in edible plants especially mango and paddy, and in meat and fish. In Andhra Pradesh

water contamination in the areas surrounding the mica mines have given rise to several health hazards such as nausea, vomiting, diarrhoea and eosinophilia, silicosis and tuberculosis.

While certain health consequences of the Bhopal gas leak were common to both women and men, women additionally suffered

⁴⁹ 'Uranium Mining in Jharkhand and its Effects on the Health of Women' presented at Eastern Zonal Consultation of 10th IWHM

from health problems that were specific to them. The gas will continue to affect generations of women. Among women who were pregnant at the time of the disaster, 43% suffered spontaneous abortions. In the years that followed, the spontaneous abortion rate remained four to ten times worse than the national Indian average. Only 50% of pre-adolescent girls who were exposed to the gas had normal menstrual cycles. It is now coming to light that even girls who were exposed in infancy and were in their mother's wombs are experiencing 'menstrual chaos'⁵⁰.

A study by Medico Friend Circle found that women who were pregnant at that time of gas exposure suffered from spontaneous abortions, still births, diminished foetal movements, and menstrual disorders.

⁵⁰ Sama- Dossier on Women's Right to Health for UGC through NHRC

Section IV

Health Policies, Programmes pertaining to Women's Health

An important feature of health policies, plans, and programmes in India is that they originated during the national movement against the colonial rule. The National Planning Committee of the Indian National Congress was set up in 1938, which also had a subcommittee on national health (Sokhey Committee). This committee made incisive appraisal of the health situation and health services of the country and recommended measures for improvement (NPC 1948). Simultaneously, the British authorities set up a Health Survey and Development Committee, generally known as the Bhore Committee (1943) that was also greatly inspired by the aspirations of the national movement⁵¹.

Some of the guiding principles adopted by Bhore Committee were:

- (i) No individual should be denied adequate medical care because of inability to pay for it;
- (ii) The health services should provide, when fully developed, all the consultant laboratory and institutional facilities necessary for proper diagnosis and treatment;
- (iii) Health program must, from the beginning, lay special emphasis from preventive work;
- (iv) Medical relief and preventive health care must be urgently provided as soon as possible to the vast rural population of the country;
- (v) The health services should be located as close to the people as possible to ensure maximum benefit to the communities served:



These principles of ensuring protection and promotion of health and nutrition of the people were enshrined through the Directive

⁵¹ Banerji, Dehabar (2001) "Landmarks in the development of Health Services in India" Imrana Qadeer, Kasturi Sen, K.R. Nayar (ed) Public Health and the Poverty of Reforms. Pg 43, cited in Sama- Dossier on Women's Right to Health for UGC through NHRC

⁵² ibid pg 44

Principles for the State Policy in the Constitution of India⁵². Thereafter, some far-reaching developments happened in the public health system in India through vertical programs, primary health centres, social orientation of medical education, Family Planning/Welfare Program, water supply and sanitation, nutrition, Minimum Needs Program, the Multi-Purpose Workers' Scheme, the Community Health Volunteers (Guide) Scheme, and the Statement of National Policy⁵³.

However, this political will was short lived and after the 70s the next three decades saw a sharp decline in the quality of health services in the country. The major forces behind this decline were:

- Obsessive preoccupation with the Family Planning Programme at the cost of serious neglect of other health service needs of the poor (a 10,000 fold jump in resource allocation, from Rs.6.5 million in the First Plan to Rs. 65000 million in the Eighth Plan).
- The imposition of so-called "international initiatives in health", through a combination of development aid agencies and international organisations.
- Involvement of agencies like World Bank and IMF in shaping social, economic and political policies of the country in the name of Structural Adjustment Program and pressures towards privatisation from 80s onwards.

This shift of trend in the public health sphere gained impetus after the Alma-Ata (1978) declaration when the global powers opposed the principles of sharing of power and distribution of resources and invented the idea of "Selective Primary Health Care"⁵⁴. This gave rise to vertical programs that compromised the provisions of the comprehensive health services. Comprehensive Primary health care (PHC) stresses prevention rather than cure. It relies on home self-help, community participation, and technology that the people find acceptable, appropriate, and affordable. It combines modern, scientific knowledge and feasible health technology with acceptable,

⁵² Banerji, Debabar (2001) "Landmarks in the development of Health Services in India" Imrana Qadeer, Kasturi Sen, K.R. Nayar (ed) Public Health and the Poverty of Reforms, Pg 44, cited in Sama- Dossier on Women's Right to Health for UGC through NHRC

⁵³ Sama- Dossier on Women's Right to Health for UGC through NHRC, 2006

⁵⁴ opcit Pg 43

Towards the National Health Assembly II

effective traditional healing practices. Of special importance for women is that the effectiveness of PHC depends very much upon community acceptance of the primary health care workers, most of whom are women.

On the other hand, the vertical programs were not only technocratic and superimposed on the masses they also made global South (India being one of the major debtors) dependent on the North for funds, supply of vaccines and other logistic support. Hence despite the weaknesses of these programs, in terms of their economic, administrative and epidemiological sustainability, they were pushed through for political reasons rather than out of consideration for real needs of such programs in the country. Thus, over the last fifteen years India has witnessed a sharp decline in the state's commitment to public health. Today our country has the fifth lowest public health expenditure in the world. As the National Health Policy admitted, this is, at 0.9 per cent of the GDP.

The poor health of Indian women has been a concern on both national and individual levels for the last few decades, yet the question remains - are women's health needs ever taken seriously? Women have been central targets of the family planning programme from the late 1960s but their reproductive health needs were never acknowledged beyond the survival of the child nor was there any concern to have an integrated/holistic approach to deal with their health issue. As of now, the field of women's health in India is full of "resounding policy and research silences, misdirected and partial approaches, and insufficient attention to critical issues such as co-morbidity or the reversal of the traditional gender paradox in health"⁵⁵. In many ways these problems in India mirrored a global lack of attention to gender equity in health.

Although the private sector provides about 80 percent of health care in India, the government is the primary source of primary care and preventive services such as immunisation and family planning.

⁵⁵ Sen Gita Whither women's health <http://www.india-seminar.com/2004/537/537%20gita%20sen.htm>, cited in Sama - Dossier on Women's Right to Health for UGC through NHR

There were a number of policy shifts after the 1990s that impacted upon women's both directly and indirectly. These include:

- (i) the economic reforms agenda which emphasises on liberalisation, reduction in subsidies in different industries, and controlling the fiscal deficit through market-oriented development;
- (ii) a paradigm shift in the national population policy that reflect the ICPD ethos of meeting the reproductive and sexual health needs of individuals and couples;
- (iii) growing concern over HIV/AIDS and its increasing 'feminisation' as it spreads from high-risk groups into the general population; and
- (iv) recognition of different forms of violence, in the private and public realm as a health issue and human rights violation in accordance to the principles evolved in the 1993 Vienna Conference on Human Rights and the Fourth World Conference on Women of Beijing (1995).

Overall, government spending on health represents is only about 1.3 percent of the gross domestic product. In addition to general health services provided to all people, public sector services to meet the specific health and nutritional needs of Indian women are provided through the Family Welfare Program of the Ministry of Health and Family Welfare (MOHFW) and the Integrated Child Development Services (ICDS) Program of the Ministry of Human Resources Development and newly construed Ministry of Women and Child Development that was only a department under the MOHFW till 2005.

Ever since the first family planning program several policies and programmatic interventions have taken place to meet the health needs of the women. However, all of them have been critiqued of having a myopic vision of health, limiting women's health to specific reproductive health needs. The development of health policies ranged from Family Planning Program (FPP 1952) with its 'clinic approach' and women centric sterilisation approach that later expanded its services to include Maternal and Child Health (MCH) and Child Survival and Safe Motherhood (CSSM) programme in 1992 which were designed to improve the overall health status of women and children and reduce Maternal Mortality Rates (MMR), Infant Mortality

Towards the National Health Assembly II

Rates (IMR) and Child Mortality Rates (CMR) by addressing the main causes of morbidity and mortality. After ICPD in 1994, the country's commitment to women's right and reproductive health care was reflected through the formulation of Reproductive and Child Health (RCH) programme in 1997.

Simultaneously various schemes and extended programmes like the Integrated Child Development (ICDS) programme (1975), National Nutritional Anaemia Prophylaxis Programme (NNAPP) in 1970, National Nutrition Policy (NNP) 1993; and vertical measures like National Universal Immunisation Programme, National Tuberculosis Control Programme and National Leprosy Eradication Programme were launched to address the health and nutritional requirements of women and children.

From the policy side, a National Mental Health Programme (NMHP) was also launched in 1982. This document shifted the basis of practice from the traditional (psychiatric) services to community care. However, in reality the NHMP is only a footnote to the national health policy, and does not offer any (fiscal or technical) supports for building community initiatives. In practice the handling of mental health problems is still heavily relying on the bio-medical model and limited to the dispensing of drugs. The District Mental Health Programme (DMHP) was launched in 1996-1997 in 4 districts, one each in Andhra Pradesh, Assam, Rajasthan and Tamil Nadu and by 2000 it was extended to 22 districts in 20 states, with a grant assistance of Rs. 22.5 lakhs each⁵⁶.

Policies & Programmes

Some of the policies and programmes that address health problems of the women are:

Reproductive and Child Health (1997)

A national programme was launched in 1997 to provide integrated health and family welfare services for women and children.

⁵⁶ <http://www.mohfw.nic.in/kk/95> As cited in Sama- Dossier on Women's Right to Health for UGC through NHRC

The programme aimed at improving the quality, distribution and accessibility of services and to meet the health care needs of women in the reproductive ages and children more effectively.

The components of RCH include prevention and management of unwanted pregnancy, services to promote safe motherhood & child survival, nutritional services for vulnerable groups, and prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), reproductive health services for adolescents, information on health, sexuality and gender, education and counseling & establishment of effective referral systems.

The second phase of the programme, RCH II seeks to address the inaccessibility problem of the population by re-looking at the location of sub-centres, PHCs and CHCs, working in convergence with other departments such as ICDS, Water and Sanitation etc. It also aims at upgrading the RCH facilities at the PHC by providing for obstetric care, MTP and IUD insertion. Hiring of private anaesthetics where anaesthetic is not available and referral transport facilities of poor families are some of the components of the Programme. However, comprehensive emergency obstetric and newborn care is only available at the First Referral Units (FRUs) at the sub-district level.



Thus despite the commitment for a comprehensive package of services the programme continue to focus on ante-natal care while Emergency Obstetric Care (EmOC) and delivery care is completely neglected and continue to elude the majority of rural women.

⁵ Mavalankar Dr Dileep V (2001) 'Policy Barriers Preventing Access to Emergency Obstetric Care n Rural India'; Public Systems Group-IIM, Ahmedabad

Towards the National Health Assembly II

The still high MMR is because of policy level barriers that restrict access of rural women to life saving emergency obstetric care in rural India. They restrict basic doctors (MBBS) from performing

In spite of such programmes, why do pregnant women still die in villages?



obstetric surgical procedures including cesarean section even in remote areas where there is no specialist obstetrician available. The para-medical staff such as the Auxiliary Nurse Midwife (ANM) is also not allowed to manage obstetric emergencies in rural areas. The policy also does not allow nurses or basic doctors to give anaesthesia⁵⁷. As there is limited number of anaesthetists in rural areas, this further reduces access to life saving emergency surgery. New blood banking rules are very utopian, requiring many unnecessary things for licensing of a blood bank. Due to this, already limited access

to blood transfusion in rural area has further reduced.

While the RCH programme entered its second phase, a five-State social assessment of RCH I (1997-2002) revealed that: health services were not available at suitable timings for beneficiaries; unresponsiveness of the health system to problems concerning mobile population; complete neglect of adolescent health needs; low priority accorded to treatment of gynaecological morbidities among women even as the untreated side effects of contraceptives and post delivery complications continued to burden women; failure to involve men in the programme, thus rendering the RCH programme as 'women centric'.

National Population Policy (NPP 2000)

The NPP adopted in 2000 lays out several objectives and goals to realize the long-term objective of 'stabilizing population by 2045 at a sustainable level'. These include meeting the unmet need for

⁵⁷ Sama-Resource group of Women and Health (2005) Beyond Numbers Implications of the Two-child Norm

contraception, health care infrastructure and personnel; providing integrated services for basic RCH care; and bringing down the Total Fertility Rate to replacement levels by 2010. The policy also states Socio-Demographic Goals to be achieved by 2010 such as – reducing MMR; achieving universal immunisation, access to information/counseling, registration of births & deaths, marriages and pregnancy; containing spread of infectious diseases; promoting small family norm etc. While the international debate (ICPD) did transform the population discourse in India and the policy spelt out shift in focus on women from fertility to overall health concerns and advocated a 'target-free approach', it still covertly chased targets and attempted at 'stabilizing' the population by controlling women's fertility, more so overtly reflected in the State population policies in the form of disincentives and incentives and the coercive 'Two Child Norm' that violated the rights of women and children. As studies show⁵⁸, some off-shoots of this norm are that it shifted the whole burden on women and marginalized them, further decline in the sex-ratio and increase in SSA, increase in girl child being given up for adoption and decreasing political participation of women.

National Health Policy (NHP 2002)

Based on an earlier policy of 1983, the new policy deliberates on the need to improve access to health services among all social groups and in all areas and proposes to do so by establishing new facilities in deficient areas and improving those existing. Recognising that women and other "underprivileged" groups are most affected by poor access to health care, it aims at improving such groups' access to basic services. Most importantly, the central government is to give top funding priority to programs targeting women's health. The policy sets forth several time bound objectives

NHP targets reduction of MMR, IMR, and mortality due to TB, malaria by 2010 and zero growth of HIV/AIDS by 2007.



⁵⁸ Kapilashrami, Anuj (2006) 'Women's Health: A Decade of Skewed Priorities' in From Shadows to Self- NGO Country Report 2005: Beijing +10, India Women's Watch, cited in Sama- Dossier on Women's Right to Health for UGC through

Towards the National Health Assembly II

including reduction of MMR, IMR, and mortality due to TB malaria by 2010 and zero growth of HIV/AIDS by 2007.

National AIDS Control and Prevention Policy (NACPP 2002)

First launched in 1986 the new policy aims at containing the HIV/AIDS transmission and reducing the disease impact on infected persons on health and social well being of general population. It notes that “gender disparity is responsible for the spread of HIV transmission” and makes a special mention about the protection of rights of HIV positive women in making decisions regarding pregnancy and childbirth. The government programme is silent on the suffering and dilemma of women affected by HIV/AIDS who are often disowned or dispossessed of their rights (to residence, maintenance and family property⁵⁹). Widowed early these women are left with no social support and legal protection because of the absence of support and sustenance mechanisms outside family. The implementation programmes overlook women’s concerns and fail to address factors that impede adoption of contraceptive measures.

National Policy for Empowerment of Women (NPEW 2001)

Suggests a holistic perspective on women’s health, which includes both nutrition and health services, be adopted and special attention be given to the needs of women and girls at all stages of the lifecycle. It also commits towards equal access of women to health care, elimination of all forms of violence against women and girl child, quality education at all levels, career and vocational guidance, employment, equal remuneration, occupational health and safety, social security and public office.

National Rural Health Mission (NRHM 2005)

Launched in 18 states, that was identified as having poor health indicators emphasizes on comprehensive primary health care for the rural poor. The mission has been perceived to provide for effective

⁵⁹ Dasgupta, Dr. Rajib (2006) 'Quality Assurance in the National Rural Health Mission (NRHM) Provisions and Debates' in Background Papers for MFC Annual Meet. Sama- Dossier on Women's Right to Health for UGC through NHRC

health care facilities and universal access to rural population in these 18 states. The principle thrust areas as defined by the document are- all "Assured Services" as envisaged in the CHC should be available, which includes routine and emergency care in Surgery, Medicine, Obstetrics and Gynaecology and Paediatrics in addition to all the National Health programmes; and all support services to fulfill these will be strengthened at the CHC level⁶⁰. All of these are attempts to establish the horizontal linkages of various health programmes and provide comprehensive primary health care rather than promoting the vertical programmes which has till now failed to provide health for all.

Why do these policies never talk seriously on domestic as well as other violence?



NPEW 2001 identifies the problem of the declining sex-ratio and recognizes it as an example of gender disparity and attempts to go beyond aggregate numbers of women and insist on the availability of good and accurate micro-level data on births, deaths and marriages. However, this policy also endorses the commitment to population stabilisation as contained in the NPP 2000. On the other hand neither the NPP 2000 nor the draft of NHP 2001 considers the steady decline of the female-male sex ratio over the few decades as a cause of concern⁶¹.

Neither the NPP 2000 nor the draft NHP 2001 takes up the issue of violence against women and girl children. There is no discussion on the links between women's health, women's reproductive health and violence in either of the two documents. NPEW 2001 commits itself to the elimination of 'violence against women, physical and mental, whether at domestic or societal levels, including those

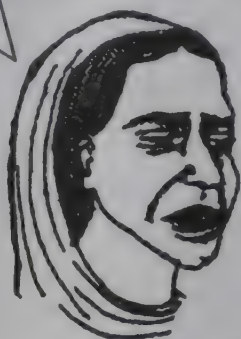
⁶¹ Das, Abhijit (2002) 'The Current Policy Scenario in India' in Renu Khanna, Mira Shiva & Sarala Gopalan (ed) Towards Comprehensive Women's Health Programme and Policy. SAHAJ for Women & Health (WAH), Sama- Dossier on Women's Right to Health for UGC through NHRC

Towards the National Health Assembly II

arising from 'customs, traditions or accepted practices', through the creation of institutions and mechanisms for prevention, rehabilitation and punishment.

The draft NHP 2001 refers to mental health as a disorder seriously affecting the quality of life but do not mention the specific mental

NHP documents do not mention about health issues of aging women like us!



health problems of women, nor does it outline any strategies to enable and encourage women to seek help. The NPEW 2001 and NPP 2000 make no mention of mental health problems of women and none of the three documents talk of the misuse of the Mental Health Act vis-à-vis women.

The draft NHP 2001 does not make any specific mention of malnutrition, or suggest strategies and interventions to tackle the issue. The NPEW 2001 targets only specific women in pregnancy and lactation stage.

None of the documents mentions about the health problems of ageing women and how to address them, except increased requirement of geriatric care in draft NHP 2001. While the NPEW 2001 refers to 'elderly women' as a sub-group of women in difficult circumstances, it makes neither commitment nor reference to their health needs⁶².

Though draft NHP 2001 speaks of the increasing role of private sector in secondary and tertiary level care and speaks of the need for monitoring, licensing and regulating diagnostic centres there is no concrete proposal for a regulatory mechanism. It makes no mention of the need to licence and regulate prenatal diagnostic centres.

NRHM 2005 has been criticised by health activists and women's groups alike as being 'old wine in a new bottle' since the Rural Family Welfare programme including the RCH II package appears to be the

⁶² People's Rural Health Watch of Jan Swasthya Abhiyan (2005) Action Alert on National Rural Health Mission, Sama- Dossier on Women's Right to Health for UGC through NHRC



main financial instrument of NRIIM. Not only that, the performance indicators of the health worker (Accredited Social Health Activist-ASHA) are related to RCH and there is a high possibility that this disproportionate emphasis on family planning and RCH will undermine the effectiveness of other primary health care components.

Thus while most policies and programmes in spirit assert the centrality of human development and gender equality and equity to some extent, they suffer from serious limitations at the implementation level. Recent trends in public and policy awareness about women's health needs and concerns, and actual access by women to the means and services to address those concerns show complex and contradictory tendencies.

Challenges & Demands⁶³

Women continue to be denied their health rights in terms of access to comprehensive information and basic services for health and essential and obstetric care. Quality of care remains a grave problem in absence of any legal mechanisms of ensuring adherence to minimum standards and guidelines. Moreover, lack of redressal mechanisms within the health system are resulting in malpractice and violation of basic human rights as in sterilisation camps.

Measures to improve social determinants of health need to be adopted, as health is not merely 'freedom from disease' but an indicator of the quality of life. Hence, promoting measures such as access to employment, job security, schooling (and higher education), equal opportunities, benefits and wages, access to resources within

- Revoke two child norm
- Ensure women's right to health and quality of care
- Provide legal mechanisms for ensuring adherence to minimum



⁶³ Anuj Kapilashrami. Women's Health: A Decade of Skewed Priorities, from Shadows to Self: NGO Country Report Beijing + 10. India Women's Watch

standards and guidelines

- Provide redressal and establish accountability mechanisms, which would include dalit, adivasi and women from other marginalised communities to prevent malpractice and violation of women's right to health and monitor the public and private health sectors
- Adopt measures to improve women's access to the social determinants of health - access to employment, job security, schooling (and higher education), equal opportunities, benefits and wages, access to resources within family and community
- Women's right to health cannot be achieved until her right to various social determinants is attained. Therefore policies, laws, programmes that look at food, water, employment, livelihood, education, violence etc must make the linkages with women's health and vice versa. Health policy, programme must make the linkages with the larger determinants of health
- Increase budgetary allocation on health, particularly in primary health care; do gender budgeting
- Priorities allocation of resources to women's health, not restricted to Family Planning etc
- Recognize Violence as a public health issue and provide quality services for the same.
- Stop coercive sterilisations and indiscriminate testing of technologies on women – contraceptives, assisted reproductive technologies, sex selective abortion etc
- Make quality health care accessible to all women especially the poor, the tribal, the *dalit*, and women from other marginalised communities

In order to ensure good quality healthcare for women, it is essential to strengthen the Public Health System and make it accessible for ALL women!



Section V

Medicines and Women's Health

Men and women who are in situations of privilege i.e. the social economic determinants of health, ensure that ill health does not take place and if it does they have enough purchasing power to ensure access and affordability of quality medical care do not suffer much. Unfortunately for large number of women this is not so, they face ill health, discrimination, non-access to healthcare and medicines. Medicines are a significant aspect of medical care in terms of cost as well as in effective treatment.

In India there is a pluralistic existence of health systems. Some having historically evolved from over 5000 years, e.g. *Ayurveda*, some evolving later e.g. *Siddha*, *Unani* and some even later in the past Century e.g. *Homeopathy*.

Allopathic medicines evolved out of the western medical model, with a reductionist approach, earlier having been **chemical** based, and their increasingly being based on **medicinal plants** and moving now to **biotechnology**, give therapy etc.

Allopathic medicine is deeply rooted in the west and in western science, the corporate world of Research, manufacture and trade. It is because of this that its control on the nature of medical care prevalent is tremendous, resulting in increasing commercialisation, allopathisation and pharmaceuticalisation of health care policies and programs. This growth and control of the 'medical industrial complex' was called **neocolonialism** by Dr. Hafden Mahler, former

Access to essential medicines is one of the major components of the PHC approach

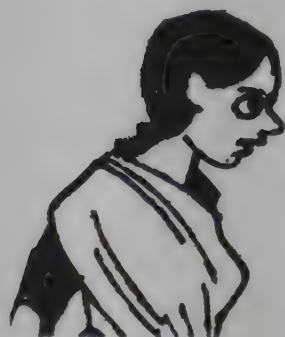


Towards the National Health Assembly II

Director General, WHO and the Chief Architect of Alma Ata Charter on 'Comprehensive Primary Health Care' 1978.

In view of the neocolonisation and the global nature of the pharmaceutical issue, and negative effects of the increasing economic globalisation under WTO, especially TRIPS, bilateral and regional trade agreements, it is the poor, the marginalized specially the women and children who are negatively affected the most. As medicines are needed to save lives, prevent or treat complications and suffering are neither accessible nor affordable, as public health systems collapse, as

Stop politicising!
At least with
drugs!



an outcome of the health destroying policy initiatives.

Over the years the Pharmaceutical Policy 1978, 1986, 1994 (2002) and the Pharmaceutical Policy Draft of 2005 has been prepared by the **Chemicals Ministry**, which is the nodal ministry for the Pharmaceutical Policy making, specially its manufacture, trade and pricing aspects.

The **Health Ministry** addresses the safety, quality aspects besides preparing the Essential Drug List, the National Drug Formulary, the Standard Treatment Guidelines for different National Health Programs e.g. TB, Malaria, HIV/AIDS.

The **Commerce Ministry** has addressed the issue of patients and TRIPS which has serious implications for 'access' and 'cost' in the future.

Pharmaceuticals & Women's Health Related Concerns

Access to Essential Drugs

The WHO Essential Drug List was first drawn up in 1977. It has been revised several times over the years so also has the National List of Essential Medicines initially in 1996 and now revised in 2003.

Unfortunately the *formulation* of the Essential Drug list does not ensure that these essential drugs are manufactured and distributed as a priority, specially those medicines specifically needed by women for reproductive health and their general health.

Especially important are essential medicines needed for reproductive health, maternal health to decrease maternal mortality, which is amongst the highest in the world.

For the known causes of maternal deaths, which are bleeding, anemia, Eclampsia, infection puerperal sepsis, unsafe abortion, obstructed labour, women need medicines that are affordable and accessible e.g. for anaemic women Cheap ferrous sulphate (iron) single ingredient, which has been replaced in the market with costly combinations of iron, in many of which the iron is in sub therapeutic doses.

If emergency obstetric care is required to save lives e.g. in ante-partum hemorrhage, post partum hemorrhage, obstructed labour etc. Blood, Oxygen, Anaesthesia are required. Under the Drugs and Cosmetics Act and WHO's Essential Drug List, blood, blood products and Oxygen are essential medicines and so are safe anaesthesia drugs, which are to be administered by medical personnel, trained and skilled in use of anaesthesia, specially in the peripheral CHC, District hospitals.

To deal with *Toxemias of pregnancy* i.e. Eclampsia, pre-eclamptic Toxemia (PET) and hypertension, anti-hypertensive, safety and adequate drugs are needed.

To deal with Puerperal sepsis and other infections e.g. Reproductive Tract Infection, Sexually Transmitted Diseases, unsafe abortions, *antibiotics* are needed.

To deal with *systemic infections* during pregnancy before and after e.g. Malaria, TB, Hepatitis, Typhoid, Kala Azar specific treatment is needed *in specific dosages, specific frequency and for specific duration*.

This is important not merely to ensure effective treatment, but also to ensure that irrational and haphazard use of antibiotics and anti-microbicides does not result in *emergence of Drug Resistance*.

Contraceptives

Safe and effective, including emergency contraceptive (4 tabs of oral contraceptives) following rape etc., are needed by women the latter to prevent unwanted pregnancy, unsafe abortion. Information about safe effective methods, fertility awareness, herbal-based contraceptives, more methods should be made available. Unbiased information about medical technology, safety aspects of medicines must be communicated in a manner understood and also about alternatives which should be available as an option.

Where pregnancy is concerned many drugs like Thalidomide, Diethyl, Stilbaestrol, High Dose Estrogen Progesterone are known to cause congenital malformation of the unborn foetus, resulting in teratogenic effect of drugs

Women who have diabetes, hypertension or suffer from mental disorders e.g. depression, bipolar disorder, MDP, Schizophrenia, Asthma require medicines for a larger period, These medicines must be made affordable.

Safety

Safety aspects of medicines for women are important, not merely because of the medicines that could affect their lives and kidneys, where they are metabolized, but also because they could affect the

unborn foetus if taken during pregnancy. Women, who are already malnourished, underweight, have had hepatitis or hypertension, urinary

tract infections affecting their kidneys, many potent drugs metabolized in the kidneys would obviously have a negative effect. These drugs should be avoided and safer alternative used.

Ignorance about the teratogenic effect of drugs, and ignorance about the existence of pregnancy when prescribing drugs results in drugs considered unsafe during pregnancy or unsafe for the mother and the unborn foetus. Similarly several drugs given to the *lactating mother* can negatively affect the breast fed baby.

Over 76 categories of hazardous and irrational medicines have been banned over the years by the Drug Control Authorities and ban of some was asked for under Public Interest Litigation filed by Drug Action Groups e.g. DAFK, AIDAN, NCCDP. Case went on over 68 years. Many of these drugs were equally unsafe for women as they too use pain killers, cough syrups, antibiotics etc. (Ref: BBDL, Shiva, Rane, 2004)

Affordability

Since women do not control resources, even where food is concerned they eat last and least, whenever there is money involved in purchasing medical care and medicines it is often denied by family, as well as by themselves, specially if medicine and medical care costs are high with 'Fee for Service' for public medical care, and increasing privatisation of medical care. Increased drug prices due to drug policies providing higher mark up or removing price control further deny women medicines that they need, but cannot afford.



Who will provide us this information?
The ANMs rarely visit us and the PHC is 7 Km away from our village.

Unbiased Drug Information

Communicating of information about using medicines rationally and safely to the patient/consumer in an understandable way often does

not take place, resulting to medical problems which

Towards the National Health Assembly II

can even if fatal. Asking for information by women is important as part of certain medicines e.g. Chloroquin, anti-malarial if taken on an empty stomach, Metronidazole (anti-amoebic drugs) cause nausea and vomiting and can worsen existing nausea of pregnancy and certain

In order to ensure the medicines needed by women, the efficacy, essentiality, safety, affordability, ease of administration and unbiased drug information with consumer information & caution notes need to be considered. There should be rational selection of regular & sustainable supply of these medicines...



pain killers
e.g. Aspirin taken if there is peptic ulcer problem, or there is dengue hemorrhage fever or bleeding problem,

whether it is pregnancy Cante partum or post partum hemorrhage or incomplete abortion related or menorrhagia (heavy periods related to menstruation), these medicines can cause severe bleeding.

Certain anti-allergic medicines, anti-histamines, tranquillizers, sedatives, cause drowsiness, making it dangerous for women involved in factories with machines, women riding cycles and scooters.

Certain medicines should not be given to the elderly women (and men) and certain drugs should not be given to children (girls and boys) e.g. baby aspirin, tetracycline, nimuselide.

Injectable hormonal contraceptives should not be given to women with hypertension, diabetes, hepatitis, thromboembolic phenomenon (clot in the veins) and to pregnant women.

Providing unbiased drug information also means giving *comparative costs* of the same generic equivalent medicines sold under different brands. Sometimes to make unbiased information available, information has to be collected and analyzed to ensure that medicines

are used safely. There is a need to study drug prescription practices, drug consumption practices. Post marketing surveillance, which is usually not done and is important when new drugs are brought into the Adverse Drug Reaction Monitoring market e.g. anti-abortion drugs e.g. RU486.

Misoprostal are sold in the market over the counter, being taken by women beyond 7 weeks pregnancy, to women with 5-6 gms haemoglobin. With 8% failure rate i.e. incomplete abortion, women could have severe bleeding which could even be fatal if severe or in already anaemic women.

Many women die or suffer because they cannot afford or access essential life saving medicines that they desperately need. Some suffer because of serious side effects or adverse drug reactions of medicines that they use. Tertogenesis, which could have been avoided in some cases. It is unfortunately the unborn babies that suffer due to tertogenic effect of drugs and also the mothers who basically have to bear the brunt the blame, the stigma and the responsibility of the cure. (Ref: Women and Pharmaceuticals, HAI and Ban Bann able Drugs)

Trained and skilled health personnel, affordable, accessible, diagnostic facilities to ensure correct diagnosis to ensure, rational use of medicines, health infrastructure with healthcare facilities that are approachable and adequate health budget to ensure this.

With increasing health problems, double and triple disease burden in urban and rural areas, with increased push for privatisation for health service as clearly mentioned in the 11th Five Year Plan Approach Paper, with changes in economic trade policies towards corporatisation and privatisation as part of autonomous liberalisation and also as part of the conditional ties of the bilateral international trade regimes which are not only creating unprecedented inequities and inequalities but also resulting in economic growth which is basically 'jobless growth', throwing millions out of jobs that have existed and provided work with self-respect and dignity. Suicides, urban migration to illegal city slums, *jhuggi*, *jhoupri* colonies to struggle on the fringes of the cities for survival with women having no access to adequate and safe

Towards the National Health Assembly II

water, no minimal privacy for toilets, no shelter from heat and rain, creating conditions of acute and chronic ill health, not only affecting the women, but the children and their family members with no access to healthcare and no purchasing power for the privatized medical care and medicines

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